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HOW WOMEN PSYCHOLOGICALLY EXPERIENCE THEIR DIAGNOSIS OF BREAST CANCER AND ITS SUBSEQUENT TREATMENTS

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DPsychPsych

2019

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A thesis submitted in partial fulfilment of the
requirements of the University of
Northumbria at Newcastle for the degree of
Professional Doctorate

Research undertaken in an NHS Hospital in
the North of England

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- My children, Aleksis and Katrina Martindale, for their helpful advice in referencing and forming the tables.
- And finally, my cooperative research patients for allowing me to share their painful experiences.

DECLARATION

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved. Approvals have been sought and granted by the University Ethics Committee in January 2015, NRES Committee North-East – Newcastle & North Tyneside 1 in November 2015 and the Newcastle upon Tyne Hospitals NHS Foundation Trust in March 2016.

I declare that the Word Count of this Thesis is 103 890 words

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Date: 8 November 2019

ABSTRACT

Qualitative research methodology (drawing on the psychoanalytic interview method and metapsychology) was used to understand how women psychologically managed their breast cancer diagnosis and subsequent treatments. The purpose of the research was to explore what the women's psychological reactions were linked with.

Clinical observation in an NHS Hospital's Breast Unit showed that the level of psychological distress amongst breast cancer patients often bore little or no relationship with the stage or prognosis of their illness. The research question was developed that if it was not the severity of physical illness or extent of treatment, then there could be some other factors, in a woman's life, which may determine the level of her distress. The purpose of this research was to explore, from a psychoanalytic point of view, these underlying, less obvious factors. Previous literature has concentrated on specific stages of illness, treatment or personality traits but failed to further investigate any additional underlying issues in a woman's life that her distress may be linked with.

This study was given an ethical approval from NRES (REC). Ten women with newly found breast cancer were each offered four individual semi-structured interviews in different stages of their treatments. The data was managed in two ways. The first method investigated the whole illness process and what kind of psychological issues the different stages provoked in the patients as a group. The data was organised by NVivo software into five main categories according to thematic contents: 'Being Diagnosed', 'Having Treatments', 'Getting Support', 'Losses Endured' and 'Long-term Impact of Breast Cancer'. These main categories were divided into subcategories. The second method extracted short case summaries of individual patients. A questionnaire collected demographic information.

The results strongly indicated that a loss of breast (or a part of it) provoked emotional connections with earlier unresolved losses and loneliness. Recommendation: these risk factors should be examined in patients with disproportionate distress, using short questionnaires, therapeutic consultations and staff members should be offered opportunities to develop 'listening skills'.

CONTENTS

1. INTRODUCTION	1
1.1. The Incidence of Breast Cancer	1
1.2. Psychological Distress and Provision of Support	1
1.3. My Research Proposal	3
1.4. My Professional Experience and Ethical Considerations	4
1.5. Steps before Starting my Research	6
2. LITERATURE REVIEW OF PSYCHOLOGICAL ISSUES LINKED WITH BREAST CANCER	8
2.1. Relationship between Psychological Issues and the Development of Breast Cancer	9
2.1.1. Evidence for Psychological Issues Contributing to the Development of Breast Cancer	9
2.1.2. Evidence against Psychological Issues Contributing to the Development of Breast Cancer	11
2.1.3. Criticism of Previous Research	13
2.1.4. Recent Developments in Clarifying the Possible Link between Psychological Issues and Breast Cancer	15
2.1.5. Conclusions	18
2.2. Psychological Impact of Breast Cancer	19
2.2.1. The Diagnosis of Breast Cancer and Psychological Distress	19
2.2.2. Body Image and Breast Cancer	21
2.2.3. Younger Women and Breast Cancer	23
2.2.4. Longer Term Impact of Breast Cancer	24
2.2.5. Understanding Distress	25
2.3. Psychoanalytic Approach	27
2.3.1. Psychoanalytic Theory and Psychoanalysis	27
2.3.2. The Link between the Body and the Self	28
2.3.3. The Body Being Attacked by Breast Cancer	32
2.3.4. Phantasies Linked with Breast Cancer	34
2.4. Managing Distress	36

2.4.1.	Earlier Developments in Recognising Distress	36
2.4.2.	Psychological Support	37
2.5.	Focusing on my Research	40
3.	METHODOLOGY	41
3.1.	Qualitative Research Methodology	41
3.2.	The Psychoanalytic Method	42
3.2.1.	The Historical Development of Psychoanalytic Treatment Method	42
3.2.2.	Discussing the Criticism of Psychoanalysis	45
3.2.3.	The Psychoanalytic Research Tradition	50
3.2.4.	The Psychoanalytic Interview Method	54
3.2.5.	The Free Association Method	56
3.2.6.	The Human Researcher	58
3.3.	Understanding the Human Mind and Behaviour from Psychoanalytic Viewpoint	60
3.3.1.	The Importance of Earlier Experiences	61
3.3.2.	The Relationship between Body and Mind	61
3.3.3.	Dealing with Anxieties	62
3.4.	Method Used in my Research	64
3.4.1.	Choosing my Method	64
3.4.2.	My Method	67
	3.4.2.1. Recruiting Participants	68
	3.4.2.2. Interviews	69
	3.4.2.3. Questionnaire	73
	3.4.2.4. Assessing the Trustworthiness of the Data	74
3.5.	Organising the Material	75
3.5.1.	The Questionnaires	75
3.5.2.	The Interviews	75
	3.5.2.1. Patients' Reactions to the Illness Process and Short Case Summaries	75
	3.5.2.2. Categories of Thematic Contents Based on the Interviews	77

4. RESULTS	81
4.1. Overview	81
4.2. Patients' Background Information Taken from the Questionnaires	83
4.3. Patients' Reactions to the Illness Process Based on the Interviews	85
4.3.1. Psychoanalysis: Providing a Way of Understanding Women with Breast Cancer	85
4.3.2. Being Diagnosed	88
4.3.2.1. Psychological Reactions to the Diagnosis	88
4.3.2.2. Psychological Reactions to the News about the Cell Pathologies	93
4.3.2.3. Comments on Being Diagnosed	94
4.3.3. Having Treatment	98
4.3.3.1. Surgery	98
4.3.3.2. Chemotherapy	104
4.3.3.3. Radiotherapy	106
4.3.3.4. Endocrine Therapy	108
4.3.3.5. Comments on Having Treatment	109
4.3.4. Getting Support	114
4.3.4.1. Partners	114
4.3.4.2. Family and Friends	116
4.3.4.3. Staff Members at the Hospital	119
4.3.4.4. Work Colleagues	120
4.3.4.5. Emotional Loneliness	121
4.3.5. Losses Endured	126
4.3.5.1. Patients' Own Illnesses	126
4.3.5.2. Other People's Illnesses	127
4.3.5.3. Previous Deaths	129
4.3.5.4. Loss of Identities	132
4.3.5.5. Loss of Relationships	133
4.3.5.6. Comments on Losses Endured	134
4.3.6. Long-Term Impact of Breast Cancer	138
4.3.6.1. Impact on Body	138
4.3.6.2. Impact on Mind	141
4.3.6.3. Comments on Long-Term Impact	146

4.4. Summaries of Individual Patients' Cases	150
4.4.1. Interaction of Case Material and Theory	150
4.4.2. Forming Hypotheses	152
4.4.3. Individual Patients	154
4.4.3.1. Patient 'A'	154
4.4.3.2. Patient 'B'	155
4.4.3.3. Patient 'C'	157
4.4.3.4. Patient 'D'	158
4.4.3.5. Patient 'F'	159
4.4.3.6. Patient 'G'	160
4.4.3.7. Patient 'J'	161
4.4.3.8. Patient 'K'	162
4.4.3.9. Patient 'L'	163
4.4.3.10. Patient 'M'	164
5. DISCUSSION OF RESULTS	166
5.1. General Remarks	166
5.2. Managing Losses	166
5.2.1. Normal Losses	167
5.2.2. Difficulties in Mourning	167
5.3. Managing Emotional Loneliness	169
5.3.1. Understanding the Concept of Loneliness	169
5.3.2. The Capacity to Be Alone	171
5.3.3. Childhood Longing for 'Merging with Mother'	172
5.3.4. The 'Good Internalised Mother' Looking after Our Bodies	174
5.3.5. The Threat of Physical Illness	174
5.3.6. Basic Inner Loneliness	177
5.4. Links Between my Findings and Previous Non-Psychoanalytic Research	177
5.5. Summary of Theory	179
6. CONCLUDING REMARKS	181
6.1. My Journey	181
6.2. Suggestions	183

7.	REFERENCES	186
8.	ADDITIONAL BIBLIOGRAPHY	199
9.	APPENDICES	200
10.	PSYCHOANALYTIC GLOSSARY	225

1. INTRODUCTION

1.1. The Incidence of Breast Cancer

Breast cancer is now the most common cancer diagnosed in women worldwide. In 2012 an estimated 1.68 million women across the world were diagnosed with this illness. The most rapid increases have happened in many developing countries. However, the incidence rate for UK women is high, being sixth highest in Europe. Nearly 55,000 new cases are diagnosed in the UK every year, that means around 150 women being detected with breast cancer every day (statistics 2013 – 2015, Cancer Research UK, 2018).

My important realisation, when looking at these statistics, was, that although breast cancer has become one of the most common illnesses amongst women in the UK, the survival rates have significantly increased in recent years. This development is due to earlier diagnosis, improvements in treatment, raised awareness and the NHS Screening Programme. The most recent survival statistics available (2010 – 2011) show that around two-thirds (65%) of women diagnosed with breast cancer in England and Wales survive their disease for twenty years or more. The data from 2009 – 2013 demonstrate that survival is highest for women diagnosed aged between 60 and 69, probably due to the effect of screening and the more unfavourable tumour characteristics in younger women. It has been estimated that well over 490,000 women who had previously been diagnosed with breast cancer, were alive in the UK at the end of 2010. In conclusion, breast cancer survival is improving and has doubled in the last 40 years in the UK (Cancer research UK, 2018 and Office for National Statistics, 2018).

In a scenario where the illness is becoming more common while the surviving population is also rapidly increasing, will stretch current resources to the limit. There will be growing demands on the NHS to offer ever improving care, not just physical but also psychological support for women with breast cancer.

1.2. Psychological Distress and Provision of Support

My impression is that the NHS attends to the somatic side of the illness swiftly with physical treatment initiated very effectively. As a result, most women have a chance to lead a normal physical life after their medical interventions have been completed. On the other hand, with so many more survivors than ever before, the question remains, as to how much the illness itself and the different treatment procedures, affect the quality of women's psychological life.

The National Institute for Health and Care Excellence (NICE) guidelines for early and locally advanced breast cancer, mandate that all staff members of the breast cancer clinical team should have completed a communication skills training programme, all patients should have a named breast care nurse specialist and should be offered prompt access to specialist psychological support and, where appropriate, psychiatric services (NICE Guidance, Providing information and psychological support, 2018). NHS Policy on Psychological Help in Breast Cancer pronounces that it often helps to talk about one's feelings and this kind of support could be requested at any stage of the illness. The hospital doctor, specialist nurse or GP can make a referral to a counsellor or psychotherapist. In addition to this, the GP can lift depression by prescribing antidepressants. The additional advice is to talk to 'someone who's been through the same thing'. This choice can be arranged by several different organisations with helplines and online forums which can put patients in touch with other patients who have had cancer treatments themselves. There are also complementary therapies that can promote physical and emotional wellbeing (Breast cancer in women – Treatment – NHS Choices, 2018).

After reading through this guidance, I could not help thinking that the main emphasis of the advice seems to be the recognition and treatment of depression. I wonder whether this situation is due to the medically dominated approach to care which offers antidepressants as a main treatment. Most probably, the patient's other options would be to learn different psychological techniques how to manage her difficult feelings without understanding them any further or to try to find a 'lay therapist' as a form of another cancer patient or to have holistic therapies in order to get better again. It is also clear from the above guidelines that the psychological services are not automatically offered to anybody in which case the patient herself possibly needs to use her own initiative in order to receive this vital support. I know through my own work as a psychoanalyst and psychoanalytic psychotherapist that asking for help for psychological problems is often experienced as something embarrassing or even shameful. It can be quite a high threshold, therefore, for many women to request help by themselves. It might well be that those who need most help, are the least likely to ask for it. Many people who would benefit from psychological services, don't ask for them as they are frightened of being stigmatised (Corrigan, 2004). The stigma can then diminish self-esteem and restrict social opportunities. Cancer is still feared in our society as well as being seen as a social stigma that affects both the patient's perception of herself and the others' perception of her (Goldie, 2005).

1.3. My Research Proposal

My own thinking has been that most of the women whose early breast cancer was detected by routine screening methods and who were without any physical manifestations, will experience their illness in mainly psychological terms. 'It's all in my head', or 'it's there between my ears' are the most common comments I have heard, when talking to these women about their experiences. When there are no physical symptoms, the diagnosis may come as a real shock for most women creating huge anxieties and fears of the unknown, including the obvious threat of premature death. However, I have understood that the impression of the staff members in an NHS hospital's Breast Unit in the North of England (from now on referred to as 'the hospital') is that the severity of physical illness is not necessarily a guide to the severity of psychological distress. Hence, some of their patients may be hugely distressed even though their early detected, less aggressive breast cancer should not have created such an excessive psychological reaction. I found the staff members' clinical experience extremely interesting and was left wondering that if it is not the severity of physical illness, then there must be some other factors determining the level of the patients' distress.

My study was an exploration of how women psychologically experience their diagnosis of breast cancer and its subsequent treatments. I wanted to learn more, using my psychoanalytic understanding, about the whole illness process and the different thoughts and feelings it raised in women's minds. My aim was also to study whether there were any specific underlying factors which determined the level of their distress. If these less obvious factors proved to be common to a number of patients, this information may encourage staff members in the future to enquire about these aspects when they encounter distress in their patients. This could be important especially where the distress appeared to be disproportionate to the physical problems. By recognising those patients at risk, help could be initiated more quickly by providing relevant psychological support and counselling with a resulting improvement in the quality of their psychological life and wellbeing.

The modern treatment of breast cancer is a long-term process lasting for several months or years and including different phases, such as establishing the diagnosis, initial treatment and often prolonged adjuvant treatments. In contrast to previous research in this area, which is mainly cross sectional and superficial, I found it essential that the objective of my study was to take a longitudinal approach by following women through their illness process. There are longitudinal quantitative studies on this subject, for example the Northern Ireland Cancer Registry's Breast Cancer Publications, but my study was to be qualitative and the method psychoanalytic. My hypothesis was that this novel approach would provide greater understanding, from a psychoanalytic perspective,

of the underlying, less obvious reasons and meanings for any level of distress that I was going to find.

- **The staff members in the hospital's Breast Unit had observed that the level of psychological distress amongst breast cancer patients often bears little or no relationship with the stage or prognosis of their illness. If it is not the severity of physical illness or extent of treatment, then there must be other factors in a woman's life which determine the level of her distress.**
- **The purpose of my study was to explore, from a psychoanalytic point of view, the underlying, less obvious factors which may determine the level of psychological distress.**
- **By recognising where distress was disproportionate, these patients could be helped by relevant psychological support.**

1.4. My Professional Experience and Ethical Considerations

As my study was going to involve vulnerable breast cancer patients, it was essential to consider very carefully all the ethical issues. I have attained the highest possible training in my own field of psychology and psychoanalysis which included many years of postgraduate theoretical learning and of personal psychoanalysis where I had, as a patient, my own emotions being understood. I was aware that interviewing these patients was going to have a psychological impact on me but on the other hand, I am a highly trained professional and capable to contain my own emotions. I was confident that I am very able to understand these patients emotionally and theoretically. I am an expert in interviewing people with psychological vulnerabilities as this had been my daily work for over 30 years in my own private practice in this country. I also had lots of experience in working with NHS patients in the Regional Department of Psychotherapy as well as in House Concern, the Specialist Psychotherapy Service for doctors and dentists. Safeguarding the privacy and confidentiality of a patient has always been a fundamental issue in my work and I was skilled in managing it. In my research, the patients' anonymity was going to be guaranteed by codes and their names were not to be mentioned in any ways in transcriptions or quotes from the interviews. This all made me conclude that my own training and long-term experience with vulnerable patients were my main assets to minimise any potential risks.

My professional experience has demonstrated that people are relieved when they are able to bring their distress to interviews, put their difficult feelings into words and be listened to by a professional person. The advantages of talking have been also recognised in NHS choices (Benefits of talking therapy), NHS inform (Talking about your condition) and NHS IAPT (the government's Improving Access to Psychological Therapies). I was expecting my research participants obtaining similar kinds of beneficial experiences in our meetings. My plan was to interview every patient four times in the course of the illness process. I had also formulated a short questionnaire, in order to collect some mainly demographic background information about the patients. The first interview was going to happen very soon after the patient had been given her diagnosis, but she did not know yet the extent of her illness. The second interview was to follow soon after the breast procedure and the patient having heard the results of it. I anticipated that the 'not knowing' and all the uncertainties about the future may create the most distressful time for the patient. However, because the first two interviews were going to be very close together in time, my expectation was that they should contain the worst anxieties and give enough support. The experience in the hospital's Breast Unit was that when their patients are anxious and vulnerable, they most probably will be willing to share their distress and that such sharing helps to make the patient more able to deal with her concerns. It is also my own long-term professional experience that it is advantageous to contain distress 'here and now'. In this way valuable evidence for the study could be obtained at this point.

I want to emphasise that I had planned the interviews to be investigative but also therapeutic in a sense that they were intended to give a meaningful and important experience for the patient, helping to deepen her understanding of herself and some of her feelings which had been provoked by her illness. As the interviews were going to be fairly open, the patient did not need to talk about anything she found too distressful. Even though distress is very understandable and normal in this kind of situation, there could have been a possible scenario where the patient was not really managing her distress. I could have then offered some extra sessions for the patient between the 'official' research interviews. These sessions would have taken place at the hospital without any audio recording. Nevertheless, the patients' difficult feelings were contained in the interview sessions and nobody needed any extra sessions. Using my own professional experience, I was able to recognise if somebody had needed further help and I could have assisted her in organising that. In no circumstances would the patient have been left on her own without any form of support. If I had had any cause for concern, I would have notified the breast care team about this with the patient's permission. However, the team members were not going to be informed about the confidential issues the patient had told me unless they were seriously threatening her wellbeing, for example if she was suicidal or if she had thoughts about harming someone else. I had already arranged with the team lead of the nurse specialists in the Breast Unit that the nurse specialists were going to be available as named contacts in this kind of situation. Finally, I wanted to highlight that the interviews as such

were not going to cause any new distress to anybody, but they may have provoked 'old' underlying anxieties which already were there in the patient's mind.

1.5. Steps before Starting my Research

Because my study was going to handle highly sensitive issues with NHS patients and include direct contact with them, my first step, before starting my research, was to prepare ethical applications. I submitted my application to the Northumbria University's Ethics Panel in December 2014 and gained the ethics approval with minor amendments at the first attempt in the end of January 2015. I also started to prepare the IRAS form for the NHS Research Ethics Committee's full review. The preparation of IRAS form was a very time consuming and sometimes frustrating experience as clearly some of the questions were repetitive. I was in contact with the local NRES Committee and booked my slot with them for their full meeting in mid-June 2015 where I myself also participated. At the end of that month I was informed that my study did not get full approval by the REC. My understanding was that the REC concerns were not linked with the study itself but that my application required more details on certain issues, such as the Trust's willingness to host my study, GP involvement, supervision, complaints procedures and access to participants' personal data, in order to meet the standards of good research in the NHS.

I completed my responses to the REC concerns and submitted my re-application to them in July 2015. Unfortunately, REC's August meeting was already fully booked three weeks before their meeting and the next one was not scheduled before mid-October. This was extremely frustrating and really slowed down my timetable. Even though I was informed by the Committee that I could choose another REC to review my study, I decided to stick to the same one because this practice was strongly recommended to me by this particular REC. In this situation, I felt I needed all possible backup to help me in my re-application. At my request, the Ethics Director of UNN wrote a letter to me confirming the University's sponsorship arrangements and supporting my ability to carry out this study. I also received valuable support from my supervisors. The Consultant to the hospital's Breast Unit with his staff members provided me with a support letter, as did a colleague of mine in St Andrews University, highlighting the novel approach of my study and seeing its potential value. I also received a support letter for my re-application from my Finnish colleague, of Jyväskylä University.

While preparing my REC applications, I had also started to develop relations with the NHS Foundation Trust and had a meeting in May 2015 with the RM&G Manager. Building up contacts with the Trust demanded a lot of groundwork and for a long time my situation seemed to be quite

stuck and complicated. I was left very much in dark and could not understand why my emails were not answered or why I was passed from one Trust person to another. Finally, after persuading a lengthy phone conversation with the RM&G Manager, he explained to me that my position was a new one for them. They did not know how to 'manage' me because I was neither a full-time employee in the NHS nor a student in the X University. I was told that there was no similar kind of contract with the Northumbria University as there was with the X University. This situation caused a great deal of worry with which I felt I was left very much to my own devices. In hindsight, I think I did manage to handle the managers in the right friendly way and things started to progress finally. R&D office wanted to see my replies to REC concerns in their meeting in mid-July when my position was discussed. The result was good news as I was then informed that the Trust's R&D Committee in their meeting had decided that they were 'happy to support my study' pending a favourable opinion from REC and a full R&D review.

I participated in the REC meeting in mid-October with my supervisor. My study was given then a provisionally favourable ethical opinion, subject to the Committee receiving some further information, mainly linked with minor practical issues. Some of these matters, in my opinion, clearly did not seem to have anything to do with the ethics. Authority to confirm the Committee's final opinion was delegated to the Chair. As the responsibilities of the agencies sponsoring and hosting my study still did not seem to be quite clear for the REC, I decided to contact the Vice Chancellor of UNN who kindly confirmed the University's sponsorship responsibilities. At last, I was given the NHS Ethics Approval in November 2015 (Appendix no 1: NRES Letter).

After receiving the favourable REC opinion, I was ready to finalise my application to the Trust's R&D Committee by completing the SSI and R&D forms at the beginning of spring term 2016. The Trust helped me with numerous different forms and practicalities as did the Graduate School of UNN. After a long process which needed plenty of paperwork and phone calls, I finally received in March 2016 a letter from the Trust granting the NHS Management permission for the research to take place. Before getting the formal 'go ahead' from the Trust, I already had started to prepare for the practical phase of my study in the Breast Unit. I had the interview room organised with the help of the matron and the breast care nurses. I gave an introduction about my study both in the MDT meeting and in the special meeting for breast care nurses whose role in recruiting the suitable candidates was going to be very crucial. I then provided patient information sheets for the nurses to hand out for patients. Furthermore, in order to keep my presence known and to remind the ongoing study, I started to participate in the weekly MDT meetings where the patients were discussed. I was more than ready to start with my research as all in all, the whole process of getting the ethics approvals and the permission from the Trust had taken altogether nearly one and a half year. Once the ethics procedures were in place, I was able to proceed with the methodological issues.

2. LITERATURE REVIEW OF PSYCHOLOGICAL ISSUES LINKED WITH BREAST CANCER

There is an extensive literature on psychological issues associated with breast cancer and its treatments. I will be summarising this topic in the following way.

- Firstly, I will be looking at the evidence as to the question whether psychological issues can contribute to the development of breast cancer.
- Secondly, I will be exploring the psychological impact of breast cancer on individual patients.
- Thirdly, having gathered evidence for psychological factors in breast cancer, I will be reviewing the literature that explores these aspects from psychoanalytic and psychodynamic points of view. Especially, I will be focussing on papers on the psychological meaning of the physical illness and the sources of distress in breast cancer patients.
- Fourthly, I will be exploring the accounts of how this distress can be most usefully alleviated and hence the patient's mental health improved.

In this review I will not only focus exclusively on breast cancer. I will include also a more general account of the literature about the role which psychological aspects play in potentially life-threatening physical illnesses where these may be relevant to the specific illness of breast cancer. As my thesis solely focuses on women, I will mostly use the personal pronouns 'she' and 'her', for simplicity, including when I discuss the different studies and methodologies, even though (if applicable) these will be relevant also to men.

For this literature research I have chosen studies and papers which I think, have given answers to my above questions about psychological issues connected with breast cancer. I have used mainly the following resources:

- PubMed Central (PMC) archive of biomedical and life sciences journal literature at the U.S. National Institutes of Health's National Library of Medicine (NIH/NLM)
- The Institute of Psychoanalysis online library service
- British Library EThOS (e-theses online service)
- Northumbria University's Library Service
- University of Turku Library, Finland

2.1. Relationship between Psychological Issues and the Development of Breast Cancer

2.1.1. Evidence for Psychological Issues Contributing to the Development of Breast Cancer

There are many very old publications demonstrating that certain psychological and psychosocial elements may be contributing aspects in the development of breast cancer. Bacon, Renneker and Cutler (1952) suggested that the breast cancer patient's unresolved conflict with her mother and the following guilt about it, explained her internalised self-destructive drive. The authors concluded that this lifelong pattern of behaviour was leading up to cancer. Another study by Renneker et al. (1963) reported potentially depressive women showing clinical manifestations of breast cancer after traumatic abandonments or disappointments. The authors hypothesised that the psychological decompensation in depression was accompanied by a decompensation of biological mechanisms. Some others, like for example Blumberg, West and Ellis (1954), documented a longstanding emotional stress possibly stimulating the rate of growth of an established cancer but they also acknowledged that the patient's ability to reduce environmental and emotional stresses or to adapt herself to them, may have explained differences in resistance to cancer. Alexander (1962) hypothesised that recurring or chronic emotional stress had a cumulative physiological effect which eventually may produce chronic reversible or irreversible organic changes.

Brody (1977) emphasised cancer patients' 'massive' denial of anger suggesting that more information was needed to understand the relationship between inhibited destructive impulses and the place of malignant transformation at the cellular level. The statistical analysis by Greer and Morris (1975) indicated a significant association between breast cancer and extreme suppression of anger. Amongst older women, the researchers found excessive suppression of other feelings as well. This study was conducted by structured interviews and standard tests on the day before the operation, without knowledge of the provisional diagnosis.

Geyer (1991) in his study about the role of life events prior to the manifestation of breast cancer interviewed a group of women with a suspicious breast lump immediately after their hospital admission and before their final diagnosis was made. The semi-structured interviews covered the eight-year period prior to the hospitalisation. The author reported that life events in the severest categories were reported most often by women who were then later diagnosed as having breast cancer. Similarly, Lillberg, et al. (2003) examined the role of stressful life events in the risk of breast cancer. This Finnish Twin Cohort consisted of over 10,800 same-sex twins. The women were

followed-up over a period of 15 years with questionnaires regarding life events and the risk of breast cancer. The results indicated that individual stressful life events possibly contribute to the risk of breast cancer, and multiple major events may have a cumulative effect on this risk. Divorce and separation, death of a husband or death of a close family member or friend, were all associated with increased risk of the illness. However, the authors anticipated that the connection between psychological and physical issues might be more complicated. They questioned whether more likely the stress may trigger a hormonal, immunological or other form of physiological mechanism in a body which will then contribute to the development of breast cancer.

Hess (1995) took a slightly different approach when looking at the role of psychological factors in the development of breast cancer. He hypothesised that psychological conflicts may play a role in cancer development and that the cancer functions as a somatic defence against difficult feelings of guilt and depressive pain which can't be expressed psychically. The author suggested that if the individual fails to find any psychic solution, that is, fails to manage her distressful feelings psychologically, then her persecuting predictive dreams may represent the first symptom of cancer in her body. Similar kinds of ideas were raised by Horton (1998) in his case study where he postulated that a particular dream might be an early cue for the presence of an illness. These authors were trying to show that the body was representing symbolically something that was not possible for the person to be mentalised.

The statistical analysis by Chen, et al. (1995) similarly showed a positive correlation between severe life stress and an increased risk of breast cancer. In this study, information about life events during the past five years was collected at a time when the possibility of cancer had led to the need for a biopsy, but the test results were not yet known. An association was found between experience of previous severe life stress and the biopsies showing cancer. However, the authors speculated that breast cancer probably may have been already present microscopically more than five years before it was clinically detectable but that severe life events during that five-year period may have increased growth and multiplication of cancer cells through altering immune surveillance processes. They hypothesised that this process is presumably mediated through the endocrine system. However, the authors recognised that a woman's psychological ability to cope with her distress is a crucial determinant of her future wellbeing. These authors were also questioning whether a failure of this coping mechanism may expose the body under chronic physical stress, and this may result in pathological consequences.

Rather similar kinds of conclusions were made by Greer and Watson (1985) after Greer and Morris (1975) had indicated in the earlier work that there were significant associations between breast cancer and extreme suppression of anger. Greer and Watson (1985) too raised the question about

a possible link between an individual's coping mechanisms in distress and her biological vulnerability. They presented a hypothetical psycho-biological model and their main suggestion was that stress conditions will put individuals, who have a behaviour pattern of extreme suppression of anger, at increased risk of developing certain cancers. Under conditions of stress, these so-called C-type individuals will show a specific biological response pattern. Although emotional suppression may be implicated as a risk factor, the precise mechanism, the authors concluded, was still unclear. They underlined specific individual response patterns in this process.

The study by Peled et al. (2008) included 622 women, out of whom 255 were diagnosed with breast cancer. The results showed that young women with breast cancer diagnosis presented significantly higher scores of depression and significantly lower scores of happiness and optimism, compared to the healthy control group when measured by a Brief Symptom Inventory and Life Event Questionnaire. This made the authors presume that a general feeling of happiness and optimism has a 'protective effect' on the aetiology of breast cancer. I would strongly question the helpfulness of this kind of statement because it will just create unnecessary self-blame in a situation which already most probably will be devastating for any young woman. The authors' findings also suggested that exposure to more than one severe life event was positively associated with the illness. The conclusion was that young women, who were exposed to several severe life events, should be considered as a risk group for breast cancer.

2.1.2. Evidence against Psychological Issues Contributing to the Development of Breast Cancer

In contrast, many other studies have found no evidence to back the hypothesis that psychological factors as such contribute to the risk of developing breast cancer. A seven-and-a half year follow-up study (Michael et al., 2009) reported no independent association between stressful life events and breast cancer risk. Similarly, yet another study of over 10,000 women with no prior history of breast cancer, found no evidence that social stress or individual experiences of it were associated with development of breast cancer (Surtees et al., 2010). The findings, these authors concluded, might help to re-assess critically the common belief that stress contributes to the onset of breast cancer.

Bleiker et al. (2008) claimed that consistent scientific evidence on any positive correlation between psychological variables and breast cancer development is lacking. Their thirteen-year follow-up study of over 9,700 women reported that none of the following personality factors, such as an absence of emotional reactions, a lack of trust in one's own feelings or the so-called cancer-prone personality, were statistically significantly associated with an increased risk of breast cancer

development, with or without adjusting for the medical risk factors. A similar conclusion was made in a critical review of thirty-two studies including meta-analyses, case-control and cohort studies (Schraub, Sancho-Garnier & Velten, 2009). The results made the researchers state that it cannot be confidently concluded that life events, personality features or depression play any significant role in the onset of cancer.

Lillberg et al. (2001) recognised that even though the common belief in the general population is that stress in life increases breast cancer risk, there are only few prospective epidemiological studies on this topic. In the cohort study of over 10,500 Finnish women the follow-up period was twenty years. The statistical analysis showed no evidence of an association between self-perceived daily stress and breast-cancer risk. The same researchers (Lillberg et al., 2002a) also investigated whether life satisfaction and neuroticism were related to breast cancer risk. In this study over 12,000 women from the population based on Finnish Twin Cohort were included in a twenty-one-year follow-up period during which time they were assessed regarding life satisfaction and neuroticism. The results showed no association with breast cancer risk. The authors concluded that their findings provide epidemiological evidence against the idea that breast cancer would be more likely to occur amongst unhappy, dissatisfied and worried women. The authors postulated that an important clinical implication of these findings would be to reduce feelings of guilt amongst those women who do worry that they themselves have caused their illness. The results of yet another study on personality characteristics and the risk of breast cancer by the same authors (Lillberg et al., 2002b) did not support the argument that the personality plays an important role in the aetiology of breast cancer. This was a six-year follow-up including over 12,000 Finnish women who all completed different personality scales during that period.

It is interesting to note that in the work of Lillberg et al., the same researchers have ended up with contradictory results about a role of psychological issues in the development of breast cancer. In their earlier studies, which I have just discussed in this section, their results showed no connection between stress, personality factors and the development of breast cancer. Nevertheless, their later same sex twin study (Lillberg et al., 2003) which was reviewed in the previous section, did in fact find possible links between stressful life events and breast cancer risk. In conclusion, the authors hypothesised that stress may trigger a hormonal, immunological or other form of physiological mechanism contributing to the risk, and the whole question about this relationship may be much more complex. Furthermore, they determined that it can be very difficult to distinguish the effects of stressful life events from other important elements in the person's life; such as her coping mechanism, social support available and her physiological response.

2.1.3. Criticism of Previous Research

The idea that the more psychological stresses the person must cope with, the more probably she will develop a physical illness as a result of it, sounds to me a very simplistic way of thinking. Interestingly, some of the much earlier studies (LeShan 1966; Katz et al., 1970) had already reported that the connections between the psychological stress and the development of a physical illness were much more complicated. Moreover, Bahnson (1969) had showed exciting body-mind parallels. He stated that although many immunological and endocrine studies have a different frame of reference, the psychological and immunological considerations show many conceptual similarities. They both are dealing with the individual's 'self', on psychic or somatic levels. When illnesses, psychological or physical, develop, there is some kind of exhaustion or breakdown of psychological or physical defence systems. However, the important point here, stated by both LeShan (1966) and Katz et al. (1970), is, that it is not the actual stress situation as such, that evokes psychic distress and biological responses. These responses rather depend on that how the particular individual perceives her stress, interprets it and defends herself against it. These authors were referring to two possible options the individual has to face; either she needs to find a capacity in herself to manage her stress psychologically or otherwise her body may need to find ways of dealing with this stress.

The suggestion that the stress situation as such does not cause psychic distress but it depends on the individual's ability to manage the stress, was later discussed by Greer and Watson (1985). They hypothesised that if this suggestion was correct, then it would not be the number of stressful 'events' which are important in this development, but instead, the individual's specific behaviour and her biological responses to these events. This reason, the authors concluded, might be able to explain why the results have been so controversial when trying to show that cancer patients have experienced more stressful 'events' than the population in general. The researchers concluded that whatever the initiating agent, the promotion of cancer will depend on both the basic properties of the tumour and the efficiency of homeostatic controls which regulate cell growth and function. Homeostatic controls can be immunological, hormonal, neural and perhaps yet an unknown mechanism. Psychological factors also play a part in this postulated homeostatic control system. This research concluded that it is reasonable to assume that there is an integrated psycho-biological control system and its failure permits cancer to grow and disseminate.

The belief that psychological issues have caused the illness, is very common amongst breast cancer patients (Wolf et al., 1995). Thomson (2014) studied the beliefs and perceptions about the causes of breast cancer using open-ended questionnaires amongst over 2,700 women with or without breast cancer. The results showed that mental and emotional factors were believed to be the most common

causes for the illness. Panjari et al. (2012) also informed that the belief in stress causing breast cancer is most common. This longitudinal cohort study was carried out by questionnaires. I wondered whether the belief in stress causing the illness can be explained in such a way that it makes the individuals feel more in control of their illness because they themselves will be able to do something with their stress. In fact, in this research many women had already made lifestyle changes towards the end of the study to reduce their stress. Nevertheless, many of the risk factors reported by the breast cancer patients and general public do not correspond to the ones generally accepted by the scientific community (Thomson, 2014). This kind of situation will raise a question how these misperceptions might impact on the success of early detection programmes and those preventative programmes which are targeted to minimise specific risk factors, such as obesity, smoking and drinking. It was concluded that particularly women who have no family history of breast cancer, may play down these risks. These kinds of misperceptions ought to be corrected (Stiefel & Guex, 1996) because they can mislead some cancer patients to feel that they are in charge over their own destiny and to believe that if only they look after their psychological state, the further risks of recurrence could be reduced.

Many authors have raised the methodological problems of studies on psychological and psychosocial risk factors in the development of breast cancer. After reviewing studies of this topic, Jensen (1991) suggested that even though there are studies indicating that the risk of getting breast cancer may be related to stressful life events and difficulties in expressing feelings, especially the aggressive ones, there are major methodological limitations in many of the papers. Due to these restrictions, no firm supposition about the role of psychological factors could be found in the development of the illness. The evidence for such a causal relationship will be clearly biased and unreliable if it originates from methodologically flawed studies. The major methodological problems in these studies, the author argued, are small sample sizes, retrospective design, lack of cross-referencing for other important factors, the use of cross-sectional design instead of longitudinal one and insufficient statistical analysis.

Petticrew, Fraser and Regan (1999) carried out a systematic review of twenty-nine published studies examining the relationship between adverse life events and breast cancer. In this meta-analysis the papers were assessed for their methodological quality. The authors reported that none of these studies supported the hypothesis of a causal relationship between adverse life events and the onset of breast cancer. The limitations of retrospective case-control studies were also recognised because increased reporting of adverse life events prior to onset of illness, may be seen as a result of the patients trying to find reasons for its onset. The researchers concluded that although the poor quality of much of the research in this area is well known, even the higher quality studies showed parallel results with no association. Their conclusion was that it will be unlikely that any systematic review

can reduce the remaining uncertainty whether there is any possible association between life events and onset of breast cancer.

Dalton, Boesen, Ross, Schapiro and Johansen (2002) conducted a critical review of studies on the role of major life events, depression and personality factors in the development of cancer. The studies reviewed were only those prospective and retrospective ones where information about psychosocial elements had been collected independently of the outcome, thereby reducing the possibility of selection and memory bias. The authors pointed out shortcomings in many of the papers, stating, that for example, even the well-conducted studies on a role of major life events as risk factors for cancer failed to take account how the individuals perceived those events. The authors therefore argued that the risk factors may not be adequately assessed by just measuring external features of these events but, instead, they should be assessed by looking at more stable internal experiences of stress in the individual. In the review of evidence there was only little support for the cancer-prone personality, firstly, because defining personality is a complex task and no single personality theory is universally accepted. Furthermore, unresolved underlying biological mechanisms suggest that biological proneness could determine both personality and the person's response to psychological stress, as well as to the risk for developing cancer. Another possible hypothesis was that stressful psychological factors could affect biological mechanisms leading to impaired immune function. The authors concluded that their review showed no indication of a relationship between psychological factors and a risk of developing cancer. They stated that future studies might benefit from better-articulated hypotheses, prospective design and larger study populations to ensure statistical validity. Higher scientific quality can be achieved only by taking account the fact that psychological factors are closely related to biological, physiological and behavioural characteristics of individuals. Most importantly, psyche cannot readily be separated from soma.

2.1.4. Recent Developments in Clarifying the Possible Link between Psychological Issues and Breast Cancer

Some authors of the studies, discussed in the previous section, had already concluded that the question about the relationship between psychological issues and the development of breast cancer was much more complex and it is not helpful to approach this topic with a dichotomous thinking.

Already many years ago Donald Winnicott, a psychoanalyst and paediatrician, in his early papers in 1967-1968 (2016) had concluded that there are 'body diseases' that really are physical, but their cause is not yet understood. Here he was referring to a 'new growth', meaning cancer. I understood

that Winnicott, at this point, speculated that though the diseases were physical, it was still possible that psychological issues may influence the soma and increase a risk of disease. In her earlier papers, McDougall (1989), another well-known psychoanalyst, had stated that our normal tendencies, when events become unusually stressful for us, will be to 'act out', to replace our thoughts by action. She also mentioned individuals who habitually use action as a defence against mental pain. These kinds of people have an increased risk of psychosomatic illnesses. If we cannot allow stressful reaction to be transformed into psychological experiences, the potential emotions may be expressing themselves in a similar way as they did in our infancy, that is through our bodies and not in images, thoughts or ideas (which would be transformations or sublimations of the raw stress). McDougall (1989) called this a 're-somatisation of affect' by which she meant that a signal from the psyche returns the difficult issues back to body action and perhaps in this way creates a concrete increased risk for actual physical illness. It is important for us to understand that at the very beginning of an infant's life, it is normal that the physical 'life forces' in her body are pushing her towards being alive (Aisenstein, 2008). At this early stage it is the mother's mind that transforms and gives meaning to the infant's communications which are expressed in physical actions, for example crying expressing a range of discomforts. In time the infant internalises the mother's capacities to use her mind in order to modify actions through representations and phantasies.

The more recent research on psychological factors in the development of cancer has shown that the potential connection between the mind and body may be in fact much more complicated than what we ever have previously expected. Aisenstein and Smadja (2010) reported that some researchers in the field of biology and medicine, for example Ameisen (1999), have formulated new hypotheses concerning the innate mechanisms of cellular systems and their functions. Under normal circumstances cellular mechanisms are rigorously controlled by a complex network of information and regulation participating in the 'sculpting' of all life-forms. However, in cancer, the cellular regulation of normal self-destruction mechanisms undergoes a dysfunction and as a result of this, on one hand, the excessive proliferation of cells, may lead to development of cancer. On the other hand, the excessive destruction of cells, may lead to other kinds of illnesses, especially auto-immune disorders.

Some recent studies (Fagundes et al., 2013) have found links between childhood adversity and a greater emotional and physical sensitivity to stress later in life. The authors acknowledged that stress has well documented effects on cellular immunity, including enhanced herpes virus re-activation. This study highlighted that breast cancer survivors who had experienced more childhood adversities, had higher EBV and CMV antibody titres. In general, the elevated antibody titres to latent herpes viruses represent poorer cellular immune function. The authors' conclusion was that their findings were additions to the emerging literature which is suggesting that adverse early life experiences may

make individuals more vulnerable to immune dysregulation in adulthood and that these consequences of early adversity appear to persist across the lifespan.

Elevated inflammation levels (Crosswell, Bower & Ganz, 2014) may be indicators to predict later behavioural symptoms, disease progression and mortality with breast cancer patients, although predictors of inflammation still remain largely unknown. Similarly, in line with the previous study by Fagundes et al. (2013) this study indicated that childhood adversity, including chaotic home environment, was associated with elevated markers of inflammation in breast cancer patients' immunological system. This kind of situation may well create potential negative implications for their future health and well-being. To my understanding, the important point of these authors was that chronic psychological stress, if unable to find any other outlet, may affect the body's physiological functioning which in turn might possibly affect cellular immunity.

It remains to be seen in the future whether these more recent hypotheses might be able to establish a firmer understanding of any link between an individual's failure to psychologically manage her earlier traumas and her developing a life-threatening somatic illness as a result of this failure. We can say that many people are able to be in touch with their emotions but there are also stressed individuals who experience major difficulties when trying to process their emotions mentally. If they are unable to do that, the problem remains because this stress will continue to persist in their body. In some cases, the solution might be to 'somatise' the emotions so that they find their outlet through the body. The overstimulation of sympathetic nervous system and over-production of hormones, for example cortisones and oxytocin, may have an effect on the body, altering its immunological system which in turn may increase the body's vulnerability to illness, such as for example to breast cancer.

It is important for us to understand that in this kind of situation the resulting breast cancer is not related to the psychological meaning of breast. On the contrary, in these kinds of physical disturbances which have been created by bodily processes, the symbolising mind is being bypassed. However, these physical illnesses can have a secondary symbolic meaning which is the meaning, given to them by the patient herself or by others, following the appearance of the illness. This latter situation is very different compared with the 'traditional' psychosomatic symptoms, such as for example conversion hysteria, hypochondria and eating disorders, where the disturbance of the body is determined by the symbolic significance of psychological distress. Psychosomatic illness is a physical illness in which psychological factors have played a significant role in its formation and maintenance. Nevertheless, even in psychosomatic illness psychological factors may be only one of many other factors, including genetic, immune and environmental, and as yet other unknown physical factors.

Aisenstein and Smadja (2010) highlighted that even though, in the case of physical illness, it is tempting to establish direct causality between the failures of psychic functioning and the appearance of a somatic illness, they have been very cautious about making these kinds of assumptions. They emphasised that the development of a physical illness is a multifactorial process: biological, hereditary, genetic, environmental, historical and psychic. Similarly, Schoenberg (2007) has concluded that whilst psychological factors, such as bereavements, may act as a precipitant to the somatic illness, they cannot in themselves be considered the cause. It is also my understanding that the breast cancer cannot be just explained by purely psychological factors. I would regard it as a somatic illness the reasons of its development still being largely unknown, but it is an illness which can create powerful psychological complications.

2.1.5. Conclusions

All in all, the large and conflicting research on the impact of psychological issues in the development of breast cancer, both in poor and high-quality studies, makes it extremely difficult to create and formulate any straightforward answers to the questions about the causal factors. Likewise, for example Petticrew et al. (1999) recognised that there have been many differing reviews both in the medical and psychological literature investigating the relationship between stressful life events and breast cancer. For that reason, many of the recent reviews and textbooks often tend to conclude simply that the evidence of the psychological causes remains unclear or contradictory.

Alongside with the important research done on causal factors, I think it would be essential to concentrate further on the psychological consequences of this illness. This will potentially identify ways to improve the quality of breast cancer patients' life. Lönnqvist et al. (1981) recommended that much more useful approach for future research would be to explore better ways to support the cancer patients and help them to cope. Helping patients to cope, they proposed, may influence the outcome of the crisis and possibly also the prognosis of the cancer. Cooper (2004) suggested that even though long-term exposure to the stress situation can influence the person's body and increase the risk of developing different illnesses, such as cancer for example, the picture is much more complicated. Whether an individual finds the situation stressful or not, simply depends on the individual herself and environmental support. Cooper referred to findings (Lazarus, 1999) which have shown that similar or even identical situations can be perceived and experienced quite differently by different people. In line with some previous authors mentioned earlier here (LeShan, 1966; Katz et al., 1970; Greer & Watson, 1985; Chen et al., 1995; Dalton et al., 2002) the impact of stress needs to be seen as an individual process. As some people are more resistant to certain stressors than others, the personal meaning of the situation to the individual has therefore become central focus in many psychological approaches when trying to understand the impact of stress on

an individual. These kinds of notions have made me more convinced that there may well be in fact some underlying and less conscious issues in a person's mind which will explain her resistance or non-resistance to a certain stressor. I will come back to this question in a later chapter.

2.2. Psychological Impact of Breast Cancer

Opposed to the causal studies, where the results about the relationship between the psychological factors and the onset of breast cancer have been very contradictory, the extensive number of studies about the psychological impact on women, following from the development of breast cancer, have all demonstrated more consistent findings; the breast cancer and its treatments can have powerful psychological effects on a woman's mind.

2.2.1. The Diagnosis of Breast Cancer and Psychological Distress

I have decided to use here the word 'distress' which I think describes well the mental and physical strain and stress where an individual with a physical illness can find herself. It is a state or situation where the person is clearly suffering and needing help. Distress can include different kinds of feelings and emotions, such as anxieties, pain and sadness, and it has an impact on the person's normal level of functioning.

A diagnosis of cancer has been regarded as a major crisis which the patient has to confront (Lönnqvist et al., 1981). The initial diagnosis and treatments are often followed by an extended period of uncertainty regarding the outcome. During this period the strain which is caused by 'not knowing', may be very distressing. Various other authors (for example Achte et al., 1981), have also recognised the diagnosis of cancer as a crisis, a serious threat to the person's biological and psychological existence; to her 'self', to her whole identity and sense of security. The authors proposed that in addition to such a primary crisis the patient may face secondary crises linked with an actual incurability of the disease, its possible progression or relapse. The uncertainty of the future is a major stress factor, supported by a survey by Rodgers and Humphris (2013) which summarised the results of cancer patients' concerns. The top ranked concern chosen by breast cancer patients from the list of 55 items, was the fear of cancer returning.

Cancer patients in general manifest high anxieties and relatively low hope in the initial phase of their illness (Heszen-Niejodek, Gottschalk & Januszek, 1999). The highest anxiety in this research was found soon after the patient had learnt about the diagnosis. The diagnosis of breast cancer can be a significant traumatic experience for many women who will then suffer from different persistent

cancer-related post-traumatic stress symptoms (O'Connor et al., 2011). The authors of this study reported that low social status, poor physical and mental health, low levels of physical functioning and disease severity were all found to be risk factors for marked post-traumatic stress-symptoms. The study, in my opinion, was also showing how important the 'good enough' supportive environment is in 'holding' a struggling individual during that time.

The important concept of psychological 'holding', to which I will return later, was also recognised in another study (Yang & Schuler, 2009) which showed that marital distress is an important factor, not only associated with worse psychological outcomes, but also with poorer physical health and a steeper decline in physical activity. Significant changes in sexual well-being with constant sexual concerns have been reported by different studies (for example Reese et al., 2010; Wang et al., 2013). Feelings of shame and guilt have been also described (Giese-Davies, 2003). The results in this study showed the shame being primarily linked with a new negative body image, the guilt arising from the ideas of having caused the cancer oneself and from failing to fulfil one's usual maternal role in the family.

The study on impact of the stress at initial cancer diagnosis and during its treatments on subsequent quality of life showed that the amount of initial stress predicted both psychological and physical quality of life in later stages (Golden-Kreutz et al., 2005). The illness may also cause health related anxiety and insomnia (Rissling, 2009). In this study the data was collected by questionnaires during the period of chemotherapy. The results showed that women with breast cancer have increased vulnerability to health-related anxiety, sleep-interfering thoughts and insomnia. Similarly, the research on the sleep duration in different stages during the first 39 months period post-diagnosis indicated that patients who were treated by chemotherapy and those who gained weight after diagnosis, had an increased risk for sustained sleep duration changes, which in turn may have increased their fatigue (Alfano et al., 2011). Intrusive thoughts connected with cancer were associated with fatigue and sleep problems in the year after treatments and these might possibly be a risk factor for poorer outcomes (Dupont et al., 2014).

Lester et al. (2015) reported that distress remained elevated in the early stages of treatment but significantly decreased by six months post-treatment. On the other hand, when Costanzo, et al. (2007) examined psychological adjustment during the three months following treatment, their findings suggested that the completion of treatment may be marked by heightened distress and disrupted adjustment. Younger age predicted greater distress, a history of depression and anxiety predicted greater depressive symptomatology, whereas more extensive treatment predicted greater cancer-related anxiety. A considerable number of breast cancer patients experienced a decline in their emotional well-being (Janz et al., 2014) and depression was associated with a lower health-

related quality of life (Reyes-Gibby, et al., 2012). Depression, fatigue and sleep disturbances were often manifested as a symptom cluster (Ho et al., 2015). The authors saw the importance to intervene especially signs of fatigue because it was clearly a sign for possible future depression to develop amongst pre-menopausal women.

Some studies have found links between difficult childhood experiences and a greater distress in an individual's capacity to manage her illness of breast cancer in later life. In a study by Fagundes et al. (2012) women who were abused or neglected as children, reported more cancer-related psychological distress and poorer physical health after treatments. The findings suggested that child maltreatment is an important predictor of quality of life amongst breast cancer survivors. The authors pointed out that one reason for this association was that those who were maltreated as children, reported having less support as adults. Similarly, Janusek et al. (2013) suggested that women with greater emotional childhood neglect or abuse exhibited worse outcomes after their breast surgery. These women presented more perceived stress, fatigue, depressive symptoms and poorer quality of life, as well as lower natural killer cell activity (NKCA). The authors concluded that childhood adversity leaves an enduring imprint on an individual's life. Both studies were trying to provide some dynamic understanding that an individual's previous difficult experiences may be provoked in a crisis situation of physical illness. They showed that some women, due to their past experiences and a lack of good enough adult care in childhood, may find their psychological distress more difficult to bear in adulthood.

Campos et al. (2012) acknowledged that little is still known about how a patient's personality affects her management of distress and her adjustment to the illness. Their results showed that personality traits of self-criticism and neediness were risk factors for greater distress when trying to manage breast cancer. The authors concluded that distress may be especially significant in a dependent woman if her mind is consumed by despair and a preoccupation with the illness and if she is habitually lacking a positive attitude. Thus, feelings of helplessness and hopelessness seemed to be a risk factor. The authors recognised that their study, to the best of their knowledge, was the first one to investigate the role which both the personality dimensions of self-criticism and neediness might have in managing the breast cancer and how these factors were related to the specific distress of individual patients.

2.2.2. Body Image and Breast Cancer

By the body-image I understand a person's perception of her own body. The way the individual sees her body is shaped by her different kinds of psychological and physical experiences. Moreover, her personality and various social and cultural ideas have an impact on it. An individual's perception of

her own physical appearance can sometimes be very different from that how the others see and experience her.

The treatment of breast cancer is usually a long-term process which might mean different kinds of interventions. The first one is usually surgical procedure which nowadays often requires just an overnight stay at hospital. Other forms of treatments, such as chemo-, radio- and/or endocrine (hormone) therapy, often follow the initial surgery. Many of these treatments are bound to cause bodily changes and various side effects. Breast surgery means partial (lumpectomy) or complete (mastectomy) loss of breast tissue, often leaving the breasts asymmetrical and scarred. Breast reconstruction will need a flap from somewhere else in a woman's body which is left with clear physical marks. There may be alterations in breast and nipple sensations, changes in limb mobility or lymph oedema. Chemotherapy not only causes hair loss, nausea and fatigue, but also in some cases fingernail discolouring and hot flushes especially in younger women who will then enter into premature menopause. Radiotherapy can trigger skin reactions, discolouring of skin or long-term neurological changes. Endocrine therapy may produce weight fluctuations, hot flushes, different pains and aches, bone problems, hair thinning and fatigue. All these different physical changes can have a major impact on a woman's perception of her body image and how she sees herself in the future. Younger women who have stepped in an early menopause may feel that they have lost their sexual body. All in all, many women might feel that their bodies are not their own anymore. Something is missing, something has been radically changed or forcefully taken out from them. They are not the same women they used to be, and this can cause dissatisfaction with their 'self' feeling, the feeling who they are.

Anxiety and depression were common problems prior to surgery (Kyranou et al., 2013) and pre-surgery psychological distress correlated with post-surgery side-effects, such as pain, nausea and fatigue (Montgomery et al., 2010). I wonder how much the pre-surgery angst may be linked with the 'not knowing' what will be detected during the surgical procedure. The reality is often that prior to the operation even the professionals themselves can't give a precise idea what their findings will be. Collins et al. (2011) examined how the different surgical treatments, such as breast conserving surgery, mastectomy alone, mastectomy with reconstruction and surgical side-effect severity were affecting the woman's body image over time. The results were interesting because it was the severity of surgical side-effects, not the type of surgery itself, that had an impact on body image within the first year after procedure. However, when Kraus (1999) explored women's satisfaction with their body image after the surgical treatment, the findings showed significant body image disturbances. This was the situation despite women's active participation in decision making about the nature of procedure and despite their post-operative satisfaction with the surgical procedure they had undertaken. The radical surgery was being associated with serious body-image concerns amongst

younger women, along with physical and psychological factors (Rosenberg et al., 2013) and body image disturbance and lower self-compassion were associated with increased psychological distress (Przezdziecki et al., 2013). In a much earlier study Druss (1986) concluded that physically healthy women without any breast cancer concerns, who had had augmentation breast surgery and changes in their anatomic structure, risked fundamental alterations in their body image and modifications in their ego because these physical changes might evoke some earlier infantile psychological experiences. Here the author may have referred to some underlying unresolved psychological issues in these women's lives.

2.2.3. Younger Women and Breast Cancer

I will define 'younger women' in this connection as pre-menopausal. The breast cancer affects these women differently because they are still fertile, but the cancer treatments usually put them prematurely into menopause. Younger women tend to exhibit more aggressive forms of breast cancer which may necessitate more intensive treatments (Partridge, 2013). The impact of the disease on younger women's life can be significant. The physical effects of treatments, associated with the reduction in fertility, and psychological aspects from the diagnosis, can be overwhelming, possibly creating depression and anxieties. Depression is being strongly associated with mortality amongst younger patients with early stage breast cancer (Vodermaier et al., 2014).

Many other authors have also indicated depression being one of the main features amongst younger women and this aspect is significant compared with older women (Avis et al., 2012). These researchers concluded that the age differences in the risk of having depression post-diagnosis can be explained by the impact the illness and its treatments have on specific areas of a younger woman's life, especially on her fertility. Similarly, Gorman (2008) recognised that the issues and decisions faced by younger women are different from those of older women, including concerns about early menopause, fertility and long-term survivorship. The results of this ten-year follow-up of younger breast cancer survivors showed that reproductive concerns were associated with consistent depressive symptoms. Also, in another follow-up study (Gorman et al., 2010) the reproductive worries amongst younger women were a significant contribution to depressive symptoms, lasting for many years.

Kash et al. (1992) investigated psychological distress and surveillance behaviour amongst healthy younger women with a family history of breast cancer. Their study found that 27% of these women were defined as having a psychological distress level which needed counselling. Higher anxieties were directly related to poor attendance at clinical breast examinations. The authors recommended psychological interventions for high risk women in order to reduce distress, improve surveillance

behaviour and assure the earliest possible detection of the disease. Mothers' breast cancer can have a major impact, not merely on the patient herself, but on the whole family (Thompson, 2005). This qualitative study used interviews to explore the relationships between mothers and their adolescent daughters who were still in a process of developing their own identities. The author demonstrated that mother's illness might interfere and shift her daughter's development pattern as a young woman. My speculation is that the daughter may feel guilty if allowing herself to grow up as a young healthy woman and it may be frightening for her to identify with mother who has suffered and gone through a life-threatening illness.

2.2.4. Longer Term Impact of Breast Cancer

As I have mentioned earlier, the treatment of breast cancer is usually a long-term process, the different treatments lasting for many months, with endocrine treatment usually for five or ten years depending on the type of cancer. The breast cancer patient, unlike the general hospital patient, may often feel much worse after the various treatments, however successful these treatments might have been (Goldie, 2005). This could be especially the case if she had felt generally healthy without any symptoms of her illness in the first place. After the initial anxieties have been dealt with and the situation has settled down, the long-standing impact of the illness can be easily overlooked. However, various authors have pointed out the common and persistent nature of psychological problems following breast cancer. Postone (1998) highlighted that many studies have shown how approximately 50% of patients with various cancers experience significant psychological distress which manifests primarily as anxiety and depression. The author emphasised that it is very important to note here that most of these patients had no prior history of psychiatric problems.

Fallowfield (2002) underlined in her quality of life study that whatever surgical treatments were offered, women still had to cope with the diagnosis of having a life-threatening illness. The author continued that although effective breast-conserving surgical techniques have been developed to improve patients' quality of life, the overwhelming majority of studies continue to report the psychological morbidity being high, that is 25-30% of patients suffering from different kinds of psychological problems. Another study (Bleiker et al., 2000) found that 16% of the women were still reporting a high level of psychological distress almost two years after diagnosis. Social well-being in the first year after cancer diagnosis seemed to be a significant prognostic factor for breast cancer recurrence and mortality (Epplen et al., 2011).

It has been suggested that between 15% and 40% of all cancer patients experience significant levels of anxiety, depression or both (Parle, Jones & Maguire, 1996). This kind of maladaptive coping, the authors hypothesised, contributes to the later onset of affective disorders. Similarly, another study

found 20% to 30% of cancer patients still being in a distressed state long after the initial diagnosis had been made (Campos et al., 2012). Likewise, Burgess et al. (2005) reported that nearly 50% of the women with early breast cancer had depression, anxiety or both in the year after diagnosis and 15% were still suffering from psychological problems five years later. Long-term depression and anxieties were associated with previous psychological treatments, lack of supportive relationships, younger age and severely stressful life experiences (Burgess et al., 2005). A significant finding from this study, and one that was also an interest in my study, was that the clinical factors, that is the nature of the physical illness, were not associated with psychological problems, at any time. Based on these results, the authors highlighted the need for a specialist service in order to help the patients to manage their psychological problems, especially during the first year after diagnosis.

2.2.5. Understanding Distress

Even though the outcomes from many of the papers, mentioned earlier, provide us with useful information, it needs to be acknowledged that quite a few of these studies tend to offer mainly a kind of 'snapshot' approach which only concentrates on a particular stage of the illness or treatment or some certain personality traits. Aydin (2008) pointed out that these studies don't consider that many of the effects of breast cancer may take different forms and intensities of expression based on each woman's unique life experiences. However, there are also some studies which do deal more with psychological distress on a deeper level of understanding, taking into consideration the more unconscious elements that might have an impact on how this distress in potentially life-threatening illness is managed.

An earlier study by Strain (1979) emphasised that a long-term illness creates different psychological stresses from one person to another, all of which have their roots in a person's early childhood. The author underlined how important it is to understand the psychodynamic component in a patient's response to her illness. Achte et al. (1987) in their study of psychological adaptation in the first post-mastectomy year, stated that in order to make even vague predictions about any simple model of adaptation or quality of adjustment, much more needs to be known about the woman as a person, her life situation and social relations and obviously, about the nature of her illness. And even then, there may be still several unknown factors which can either significantly increase or decrease the individual patient's adjustment. The authors decided that there is no common response when trying to adapt oneself to mastectomy.

Fallowfield, Baum and Maguire (1986) went further into the causes of distress, suggesting that there is no evidence that less radical surgery, namely breast conservation, will in any way lessen this distress. On the contrary, their findings showed that women with lumpectomy suffered from

psychological distress just as much as women with mastectomy. These results made the authors critically question the view that mutilating treatments were predominantly responsible for the measurable psychiatric morbidity. Lipowski (1981) expanded the source of causes by suggesting that the nature and intensity of these gross psychological reactions may bear little or no relation to the objective severity of the physical illness or its treatment.

So, if it is not the severity of physical illness or the extent of surgery, then there must be some other factors in a woman's mind determining the level of her psychological distress and her ability to adapt herself to the new situation. When trying to understand the long-term psychological impact of breast cancer on a woman's life, a sensible approach to this question could be to take into account the psychological history every time breast cancer is diagnosed because, as Daune (1995) has suggested, the woman's psychic scene is invaded by her sick body. The author pointed out that with breast cancer, the symbol of femininity is compromised and the loss of the breast, partial or total, will interfere with the identity of the woman. Daune (1995) proposed that it is important to gather information about a woman's age, personality, real life experiences and psychological and psychiatric history, because psychological impact of breast cancer varies from one person to another. Similarly, Dolbeault, Szporn and Holland (1999) called for more attention and research into the care of the 'whole' patient as this kind of approach may enhance the quality of her life.

Schoenberg's (2007) concept of 'psychosomatic imagination' also adopted a more creative model highlighting that a somatic patient has to be seen as a 'whole' person, beyond her bodily complaint and including her history. He presented a special psychotherapeutic introduction scheme for first-year clinical medical students where the student will learn to understand the patient's unconscious communications and appreciate the significance of the patient's emotional development in childhood. Here he referred to Franz Kafka's (1919) words in 'A Country Doctor' that writing prescriptions is easy but to communicate with people beyond that, is difficult. Schoenberg (2007) also emphasised that the physical illness as a concrete event may provoke additional stress if the patient feels that she has no control over the situation, no social support or no sense that anything better might follow. Repeated challenges and circumstances like these, may result in a chronic state of vigilance in the individual, leading to constant anxiety. Overwhelming stress may cause helplessness and if this situation becomes prolonged and chronic, it may bring about depression and further pathologies.

Gorini et al. (2015) have recently developed Alga – Breast Cancer multidimensional questionnaire which aims to focus on each patient as an individual in order to assess her physical and mental characteristics, individual needs and preferences. The idea is to provide physicians, prior to the consultations, with a patient's profile that is supposed to facilitate subsequent communication and

to offer more meaningful care in following the trend of so-called 'personalised medicine'. Similarly, some other researchers (Baize et al., 2008) have seen the significance of psycho-oncology and requested for the socio-aesthetic issues to be more recognised in oncology practice. Psycho-oncology focuses on the patients' psychological responses to cancer at all stages of their illness, and that of their families. The psychological, behavioural and social factors are regarded as important because they may influence the patient's illness process.

In line with my own thinking, what all these researchers really tend to emphasise, is the idea that a woman's psychological reaction to breast cancer has wider links with her whole mental structure. This is also the approach of psychoanalytic understanding which I am going to introduce briefly in my next chapter.

2.3. Psychoanalytic Approach

In the following I will be focusing in a more detailed way on the literature where the psychological issues linked with breast cancer are understood from a psychoanalytic point of view. I will be concentrating on papers which are looking at the psychological meaning of physical illness and the sources of distress in breast cancer patients. However, at first, I will be briefly presenting psychoanalytic theory and how it understands the link between our body and 'self'. I will come back to the psychoanalytic treatment method and research method in the methodology section.

2.3.1. Psychoanalytic Theory

The psychoanalytic theory, as a metapsychology as well as a treatment method, originally developed by Sigmund Freud in the late 19th century, investigates personality organisation and its dynamics. It is a deterministic theory which emphasises the importance of our past childhood experiences in shaping our future behaviour and personality, and potentially influencing our mental functioning. The classical Freudian theory sees the development of our mind as a result of the interaction of three component parts: the id, ego and superego in relation to the environment. The id aspects typically consist of instinctual, physical and libidinal drives. The superego is driven by morality principles using guilt to encourage socially acceptable behaviour. In its benign protective form, the superego plays an important role. The ego tries to balance between the demands coming from the id, superego and external reality in order to maintain a healthy state of consciousness in our minds. In this way, by preventing threatening unconscious thoughts and feelings from entering our consciousness, the ego aims to protect us against different kinds of anxieties. In this process ego uses various defence mechanisms, such as repression, sublimation, regression and displacement for example. However,

sometimes the ego does fail to protect the individual from too painful anxiety-provoking realities. In this kind of situation, the ego must resort to more primitive defence mechanisms, for example denial or projection, in order to keep these intolerable realities away. In this process, the individual's external reality might be distorted. The unconscious part of our mind contains those feelings, emotions and thoughts which we are not consciously aware of. These unconscious aspects might crop up in everyday talk for example via slips of tongue, but more often via our dream world.

Since Freud's early work the psychoanalytic theory has undergone many refinements but the very basic elements in his classical model are still directing the modern psychoanalytic thinking. To summarise it very simply, psychoanalytic theory helps us to understand how our psyche works and how this functioning happens on different, conscious and more unconscious, levels of our mind. Our early relationships with parents, of their 'holding' the child's psyche and our childhood experience of love, loss, sexuality and death, all lay down patterns in our mind. Some aspects of these patterns remain unconscious but will have enduring effects on our present-day psychological functioning, even though we might not be knowingly aware of this (Psychoanalytic Theory. The Institute of Psychoanalysis, 2015).

2.3.2. The Link between the Body and the Self

The psychoanalytic approach to human behaviour is based on understanding that our 'self' and our body are closely linked with each other and this link has developed from very early experiences in an individual's life. We all carry in our minds our own developmental history, psychological and physical. In this way we all are the 'prisoners of our own past' unless we can make some internal changes in our psychic structure. It was originally Freud (1961 [1923]) who noted that our 'self', the subjective feeling about ourselves, is first and foremost based on our body. For Freud, originally a neurologist, it was self-evident that the body was the starting point from which our mind develops.

Freud highlighted the special status of a body. It is simultaneously a part of our ego, closely linked with our internal 'self' experience, but at the same time it is a part of our physical external reality. Freud saw that in the early stages of development the infant's sense of 'self' emerges from her bodily experiences which at first are linked with regulation of her biological needs and physical state. As the range of the infant's mental impressions about her body gradually expands outside her mother's sphere and her various bodily experiences are gradually synthesised, she begins to develop a primitive sense of her body's boundaries and gains a greater facility in manipulating it. The body image and concerns about it remain a central aspect of 'self-experience' throughout our life (Tyson & Tyson, 1993). As Solms (1995) has shown, our attachment to our bodies can be seen as reflecting the infant's earliest bond to her mother. We are functioning like mothers to ourselves, possibly

repeating more unconsciously those experiences we had in our infancy when we were physically looked after by our mothers.

Sletvold (2013) has pointed out how Damasio, about 70 years later since Freud's time, made his observations of the 'embodied self', meaning the embodiment of mind. Here Damasio's thinking corresponds to Winnicott's ideas that in health the person's psyche and soma go together. Damasio's (1999) remarks were based on his vast neurological and neuropsychological research. He reminded us of Freud's biological starting point and of Freud's insights on the nature of affects (feelings). Crucially, these ideas are still consonant with today's most advanced views in the field of contemporary neuroscience. Emotions and feelings are organised neurally in our brain and are distinctive on several accounts, for example being innate and being experienced in pleasure-unpleasure continuum. Damasio (1999) stressed the link between feelings and the body by highlighting the connection between mind and nerve cells in the insular cortex and brain stem structures. For him, the body, the real one and the one represented in the brain, is the theatre for the emotions. Considering this background, it is important to realise how our perception of the bodily 'self' has emerged from a long tradition of psychoanalytic thinking and is being borne out by modern developmental psychology and neuroscience.

We need to understand how the development of the 'self' is closely linked with a young infant's body and this development has a lasting influence on her later life. Winnicott (2016, [1988]) recognised that when birth happens at the normal time, a 'great awakening' occurs but this can contrast when baby is born prematurely or post-maturely. The pre-mature baby is not yet fully ready for life and the post-mature baby may be born in a frustrated state, having been ready and kept waiting. Winnicott made it clear that the basis of the mind arises in the registration of somatic sensations. The rudiments of mind are in the patterning of sensory experiences of physical needs being felt and met or frustrated, leading to memories. In this way the 'self' gradually starts to exist, but the psyche is only existent in the presence of brain and brain functioning. Winnicott (1960) also emphasised the paramount importance of early mother-baby relationship in this development of our 'self'. Some other authors, such as Hoffer (1949), Anna Freud (1971) and Edgumbe (2000), have also written about these issues but here I will concentrate on Winnicott's thinking.

Winnicott's (1965a) concept of 'good-enoughness' defended the ordinary devoted mothering against the professional experts' growing tendency to pathologise mother's actions. His message was also meant to counterbalance the dangers of over-idealising mother as a 'good object' and instead stress the importance of nurturing environment which the mother provides for her child. Winnicott (1965a) introduced the psychoanalytic term 'holding' by which he meant both psychological and physical 'holding' of an infant's needs throughout her development. The 'holding environment' also includes

the child's father, the extended family and society at large. What is very important here, is that the 'holding environment' never loses its importance even in our adulthood. For Winnicott, mother's 'good enough' physical handling of her baby's body was the starting point for the development of 'self'. Mother's technique of holding, bathing, feeding and all the other things she does for her baby, will start to foster the baby's ability to experience her body as a place wherein she can securely live. Through these purely physical experiences with her mother the infant gradually develops a sense of herself as a person. In this early development the body and mind are integrated into a psychosomatic collusion which Winnicott (1965a) called the 'psyche in-dwelling in the soma'. When mother handles lovingly her baby's body, she helps the baby to start feeling that 'her body is herself'. From this early 'personalisation', the feeling of 'self' will gradually develop. Winnicott's idea of 'true self' is based on the individual's continuous sense of 'being', an existence that is rooted in the bodily experience. As a contrast to this, there is a 'false self' which he regarded as a necessary defensive organisation when the individual is protecting her vulnerable 'true self' so that it can exist (Davis & Wallbridge, 1981; Abram, 2007). Following Winnicott's ideas of 'bodily self', Meissner (2006) has recognised that ontologically, right from the beginning of human development, the psyche has its starting point in the body and its operation is primarily dependent on brain functioning. The psyche arises as an organisation which develops and expands aspects of somatic body functioning in an imaginative way. In addition, Meissner (2006) underlined that the psyche gradually needs to 'comply with the body', meaning that it has to 'obey' the bodily functions.

Winnicott (1988) highlighted that in health, there is eventually a state of affairs in which the body boundaries are also boundaries of the psyche. A very important point here is Winnicott's emphasis on the intimate link between the 'self' and body which normally goes without notice. In other words, in healthy development, psyche and soma are not distinguishable from each other and the healthy individual takes it for granted that her sense of 'self' is her body; that is to say that the 'self' is incorporated in a person's body. We all tend to see our bodies intact and a physical illness is experienced as threatening to disintegrate our bodily ego (Solms, 1995). For some individuals the threat can create unbearable mental pain which is associated with earlier narcissistic traumas, often with loss.

Kaplan-Solms and Solms (2000) suggested that because the ego is first and foremost a bodily ego, its first object in the outside world is its own physical body. We can observe how a young baby's body is initially functioning as a source of various sensations arising from the superficial and deep sensory receptors and from major somatic needs, which constantly demand satisfaction. Freud stated that hate is older than love, and our first reaction to the constant source of stimulation from body is hatred; a wish to get rid of these bodily demands and be left in peace, to be allowed to return to the blissful state before birth. But fortunately, life forces, such as self-preservative (nourishment,

warmth etc.) and sexual drives, help us gradually to adapt ourselves to the providing world and to satisfy our biological needs for survival. The impulses arising from these instinctual sources in the infantile ego libidinise the sources that provide relief from being aroused, for example the mouth/breast that relieves the stimulation that stems from hunger. In this way our first narcissistic love relationship is our bodies which provide a discharge for different impulses. However, this relationship is ambivalent. We feel that our loved body is a part of ourselves and therefore under our omnipotent control. But there is also the unconscious knowledge that our body with its demands is disturbing our need for tranquillity, demanding our attention and therefore not being under our omnipotent control. This realisation is very important considering a situation where a person is faced with a serious physical illness.

McDougall (1989) explained that the infant's psychic life has a starting point in her experience of merging with mother. This creates a phantasy in the infant's mind that she and her mother have only one body and one mind. So, in the infant's internal world, her mother and she is one indivisible unit. Furthermore, McDougall (1989) emphasised that the mother-baby relationship needs to be 'good enough' for the early somato-psychic matrix to be able to progress towards differentiation. This differentiation means that gradually the infant becomes psychically aware of the difference between her own body and her mother's body. This experience is the infant's first representation of the external world. The psychological part of the body becomes slowly differentiated from its somatic part in the infant's mind and this is the starting point wherefrom her subjective identity will gradually develop. However, as McDougall (1989) highlighted, this gradual 'de-somatisation' of the psyche is also accompanied by the infant's wish to be totally merged with her mother, especially during moments of physical or psychological suffering. The oscillation between both wanting to merge with mother and to differentiate from her, is a normal universal tendency for all infants. As Pines (2010) suggested, the healthy striving of each child is to grow into a separate individual but at the same time, in a normal development, the child, especially, when feeling distressed, will experience a powerful 'pulling back' momentum towards the safety of the earlier developmental stages.

The girl's separation from her mother is often more complicated than the boy's because not only does she have to separate herself from her mother, but she also needs to identify herself with her. Pines (2010) continued that aspects of mother's physical presence and her emotional attitudes towards her daughter and her daughter's body, will be integrated with the daughter's experience of herself and with her conscious and unconscious phantasies. In this way, the representation of an 'internal mother' will be gradually created in the daughter's mind and, what is important, it will be a lifelong model for her. I would say that in this way, all women are carrying aspects of their mothers in their minds and also in their bodies, in good and in bad. In Pines' (2010) clinical experience, bodily expressions of unbearable feelings were more common amongst her female patients. She

postulated that this was a woman's unconscious way to avoid psychic conflicts in her mind through her bodily expressions. However, even if a woman does not use her body in this manner, she is deeply influenced by bodily changes throughout her life. Different women cope with these events, whether they are normal phases of the life cycle or unexpected serious physical illnesses, in line with their own previous histories and with their ability to manage their life problems.

2.3.3. The Body Being Attacked by Breast Cancer

We might just wonder, when following these ideas, how much a woman's sense of 'self' may become threatened and feel attacked when her body will be overtaken by the potentially life-threatening illness of breast cancer. She might feel that her body has betrayed her, and she cannot trust in it any longer. In more extreme cases, she might unconsciously fear that her early experience of her mother's handling her body, during the very early developmental phase of 'holding' (like previously described by Winnicott, 1988) has failed. This kind of experience will result in more primitive fears of breaking down, being dropped or having no relation to the body. McDougall (2013) suggested that the cure of cancer can never be definite since a satisfactory explanation of the cause of the illness has not yet been discovered. Thus, the afflicted breast cancer patient can never assume that the cause has been totally eradicated. This situation, the author pointed out, will inevitably leave the woman with both conscious anxieties and more unconscious phantasies about her illness. She may also face the reality of her own mortality.

Although we all know rationally that we will die one day, our defence mechanisms will reduce the emotional impact of this awareness. Freud (1957 [1915]) had a view that it is impossible for us in the unconscious to imagine our own death. Whenever we try to do so, we will realise that we are in fact still present as spectators. So, death anxiety cannot be analysed away as a derivative of childhood conflict. Freud concluded that since we have no direct experience with death, there is no way we can fear it. In this respect, Freud was a prisoner of his own deterministic thinking. Because death was a future event which the person had never experienced, it could not exist in the unconscious and therefore it could not influence the person's behaviour. Yalom (1980) has disagreed with Freud's view saying that the fear of death plays a major role in our experience. However, we will protect ourselves from it by using defensive phantasies, such as believing that we are special exceptions, it does not concern us or that we are rescued from it by God or an omnipotent doctor. Patients, like medical professionals, are facing their own impotence in front of death anxiety which does not mean though that all death anxiety is pathological. I would say that the nature of our death anxieties is highly determined by our past experiences of death in relatives and by our own personalities. When going through the life-threatening illness of breast cancer, these kinds of anxieties of one's own mortality most probably will be provoked in a woman's mind.

Freud (1953 [1900]) once stated that 'love and hunger meet at a woman's breast'. In psychoanalytic thinking the concept of breast is regarded as being the infant's first object, fulfilling her different needs. At the beginning of life, the mother's breast is an object of the infant's desire (Bollas, 2002). Winnicott (1953) described how the mother places her breast there, in the right place and in the right time, in order to be found by her baby. This repeated pattern gradually gives rise to a phantasy that the baby herself has created the breast. The breast also first represents for the infant the whole mother and her mothering in different ways and signifies a source of great pleasure and satisfaction. In this very early phase, there is no psychological boundaries between the baby and her mother; they are one and the same unit. The sucking during the oral phase, the first phase in the child's psychosexual development, is the main source for her pleasure. In time, after a girl's body image is formed, her own breasts become the focus of intensive cathected investment. This means that lots of mental energy is attached to her breasts unconsciously and laden, in our culture, with special significance and of eroticism (Gorman, 1964). Following the growth and development of breasts during pregnancy, the active secretion of colostrum (liquid secreted by the mammal gland) and the reflex secretion of milk are considered to be an erotogenic experience for the mother (and child). Gorman (1964) suggested that loss of breast in carcinoma (as a result of simple mastectomy) may promote breast phantoms, that is the psychological feeling of still having the breast. Women who struggled most with the phantom breast, in the author's experience, were the more regressed patients with passive dependency needs, who had never been able to assume an adult role and separate themselves from their mother's breast. The breast of an adult woman can be the location of nourishment, erotic activity but also illness, breast cancer. These areas represent feeding, love and death, all of which are the basic phenomena of life.

As we can see, the breast and its symbolic meaning have always taken such a central position in psychoanalytic theory. For that reason, I have been really surprised to realise that there is hardly any psychoanalytic research on breast cancer. There are some case studies, for example by Winnicott (2016, [1967-1968]). McDougall (2013) concentrated on removal of the breast and how it was felt to be a severe assault on a woman's body and her self-esteem causing psychological distress. She suggested that the 'mutilating' surgical treatments of breast cancer and the other treatments, such as chemo- and radiotherapy, will arouse considerable psychological distress in the affected woman. The woman may feel that she has lost her bodily integrity, her self-image and her subjective and sexual identity. The author emphasised that with the loss of the breast, the essential symbol of femininity may be felt to be destroyed. The trauma of being diagnosed with breast cancer can be also characterised by shame (Aydin, 2008). This study concluded that the woman's body, 'mutilated' now by different treatments, was a physical manifestation of punishment for her badness and was now exposed to others. The women interpreted that their physically changed bodies were now seen as their ultimate failure in their efforts to hide their 'inherent' badness.

Aisenstein (2008) called the human being a 'somato-psychic unity'. The author strongly criticised the idea that the serious physical illness affects the soma alone and thus have no repercussion on the psyche. It is also my understanding that the body and mind have a close connection with each other and that our psyche has to manage the physical illness in one way or another. Even though my study explores the psychological distress created by breast cancer, it is important for us to recognise that not all patients with life-threatening physical illness are in contact with their psychological distress. There are individuals who are leading their life in a mechanical, factual and non-metaphoric way (Aisenstein & Smadja, 2010). Their thinking is concrete, operative and empty without any feelings. These kinds of patients seem to be sensible, rational and not in touch with their emotions which critical physical illness may provoke in them.

2.3.4. Phantasies Linked with Breast Cancer

However, most patients with physical illness don't detach themselves psychologically from their disease but have phantasies about it. By phantasies I mean here imaginative, fanciful creations, mental images which are not restricted by reality principles. The phantasies can be conscious when the individual is aware of them or more unconscious but still directing the individual's thinking and behaviour, without her being aware of that. The meaning of the phantasy linked with a physical illness is consistent with the patient's psychodynamic functioning (Blumenfield, 1983). Each patient has, both at conscious and unconscious levels, a 'core phantasy' about her illness and why she has become ill. Like the body and the mind relation, the nature of the illness and the reason in the patient's phantasy for its development, can't be separated from each other.

Lipowski (1981) proposed that the patient's somatic perceptions from her body and from her social environment are consciously and unconsciously creating a meaning for her illness. The meaning then determines the patient's emotional response and her ways of coping with the illness. The author's view was that it is important to identify those dominant personal meanings of the illness which are most influential in determining the patient's emotional responses and her coping behaviour.

The cancer is often felt as having human qualities, normally described in relation to a person, such as somebody who takes control over the other person (Parkinson, 2003). The illness can be experienced as a challenge, enemy, loss, gain, relief or punishment depending on what kind of psychological meaning it has for that particular patient (Lipowski, 1981). This personal meaning of the illness is in turn linked with the individual's predominant conflicts, psychological defences, personal coping style, self-image and self-esteem, proneness to guilt and separation anxieties. I understood that, in this way, the author wanted to emphasise that the physical illness can also have

less obvious, unconscious meanings which could be only understood through listening to the patient and her life history. The more the meaning of the illness and its symptoms are influenced by these unconscious factors, the more irrational, idiosyncratic and unpredictable the patient's overt responses might be. It is therefore my own current understanding, which is also based on my clinical experience, that the less obvious, underlying factors could explain the different levels of severity in a patient's distress and why this psychological distress is not necessarily proportional to the severity of her physical illness.

Lipowski (1981) continued by proposing that the greater the subjective value and psychodynamic significance the diseased body part has for the patient, the more intense her psychological reaction is likely to be. A body part has got a special subjective value for the individual if it supports her self-esteem and sense of identity, if it helps her to maintain satisfying relationships or if it reduces her intrapsychic conflicts. The author postulated that a disease which undermines any of these key values in a person's life, will have profound psychological consequences regardless of the objective severity of the illness. From this kind of perspective, we can well realise how amongst women for whom the value of the breast stands as a major support of their sense of femininity, identity and self-esteem, the loss of it or parts of it, can have devastating consequences, even though the physical illness itself may have a good prognosis. In this way it is important to understand that the unconscious significance of the diseased organ can be a crucial factor when trying to understand seemingly unexpectedly intense psychological reactions to the physical illness.

Postone (1998) noted that even though most of cancer patients' anxieties are certainly realistic, the unconscious meaning which the patients attribute to their physical illness and treatments, is also an important factor because it frequently intensifies their suffering. The patient might have specific ideas about her illness. She may believe that she had brought the cancer on herself, that her stress had altered her immune system and that she could have treated her cancer by improving her outlook, for instance by thinking more positively or changing her lifestyle. The risk might be that some patients may be then left with a belief that having developed a cancer is a sign of their personal weakness and failure.

Similarly, Kent and Blumenfield (2011) concluded that a patient's unique reaction to her physical illness is a result of her detailed phantasies about the illness and its causes. These phantasies usually have components that involve issues from the past and present. Likewise, Achte et al. (1981) have emphasised the importance to know the subjective meaning the patient has attached to her illness and its symptoms. These authors' view also supports the idea that the symptoms and their intensity are crucially influenced by the unconscious symbolic meanings they have for the patient. Different anxieties and unrealistic attitudes can be ultimately based on the various symbolic

meanings the patient has attached to her illness (Tähkä, 1977) and the illness may actualise previously repressed emotions and unresolved conflicts (Pattison, 1974).

In this way psychoanalytic understanding about the close link between the body and mind can help us to see, how the psychological reactions to physical illness may have more complicated and deeper, often unconscious meanings, usually linked with each individual's personal history. Along these lines we can then anticipate how the loss of breast or parts of it may activate previous losses and other unresolved issues linked with separations, identity and self-esteem crises in a person's past and present life experiences.

2.4. Managing Distress

I will end my literature review by looking at psychoanalytically and psycho-dynamically orientated studies on accounts of how the psychological distress amongst breast cancer patients could be most usefully relieved and thus, how their mental health could be improved.

2.4.1. Earlier Developments in Recognising Distress

Many earlier studies had acknowledged the value of psychological input for physically ill patients. Alexander (1962) postulated that patients with certain chronic diseases had two kinds of vulnerabilities: a specific emotional vulnerability towards certain interpersonal stress situations and a vulnerability of specific organs. This kind of specific organic vulnerability, which had been acquired earlier in a person's life or had been genetically transmitted, would then develop symptoms in that organ under specific stress situations. Alexander (1962) saw that psychotherapy of patients who were suffering from organic diseases, was, in many ways, not different from psychotherapy with people who experienced psychological problems without a somatic illness. Here Alexander, when talking about 'chronic organic diseases', was referring to traditional psychosomatic illnesses (such as asthma, duodenal ulcers, essential hypertension, rheumatoid arthritis, neurodermatitis, thyrotoxicosis) in which psychological factors were suspected as having a role in their precipitation and where characteristic emotional patterns were found. An approach based on psychoanalytic thinking was used to observe these patients in order to find out their special emotional vulnerabilities. Knowing and understanding these specific nuclear conflicts were then to help the professionals to attend to the patients' psychological problems more directly.

Some other studies (for example Brody, 1977) postulated that cancer was linked with a patient's hypersensitivity to stress and immunological breakdown. Therefore, the aim of psychoanalytic

treatment was to concentrate on helping the cancer patient to verbalise especially her destructive emotions. In this way, the goal was, to diminish the patient's stress reactions and to strengthen her immune system and thereby defences against neoplasia.

2.4.2. Psychological Support

It has been increasingly recommended that the psychological support should be a vital part in routine cancer care. Goldie (2005) argued that psychotherapeutic approach can make a difference for many patients in a busy hospital setting where the avoidance of subjective feelings about the illness, is often the aim. No one has the time or resources to sit down and listen to patients' anxieties. Goldie (2005) compared the impact of cancer diagnosis to a 'war experience' which, if becoming fixed and predicting the patient's future, can force her to adopt a helpless position. This kind of situation will threaten her capacity to deal with her illness in a more active way. Psychotherapeutic approach treats the patient as a unique individual and does not attempt to classify her in any diagnostic box. In many ways the setting and arrangements are similar to the ones used with other psychotherapy patients, even though modified for the needs of somatic patients. Some of the main themes that correspond to usual psychotherapeutic approaches, are to protect the patient's privacy and confidentiality and the consistency of the same therapist, even though the physical setting might change.

The 'Quality of life' studies (Fallowfield, 2002) concluded that all women with breast cancer, not just those going through mastectomy, should have access to supportive interventions. In all cases where patients' emotional reactions are very intense, excessive or prolonged, psychotherapeutic treatment should be offered (Achte et al., 1981). Likewise, the anxieties during radiotherapy treatment need to be identified and appropriate support to be offered throughout this treatment (Lewis et al., 2014). All cancer patients must be screened as regards their distress and psychosocial needs which should be then addressed in the patient's treatment plans. Patients with high levels of distress need to be referred to a 'proper' psychological resource for help (Lederberg & Holland, 2011). The authors emphasised the therapist's flexibility when treating cancer patients because their needs may vary depending on the level of the illness and possible side effects of the treatments.

Psychological intervention, at the time of the diagnosis and up to nine months after that, lifted the depression and improved the quality of life amongst the patients with non-metastatic breast cancer who were assigned to surgery and systematic chemotherapy (Marchioro et al., 1996). Similarly, a supportive-expressive group therapy for recently diagnosed breast cancer patients was found to be significantly reducing their distress (Spiegel et al., 1999). Schoenberg (2007) has suggested that group therapy can give patients an additional opportunity to interact and support each other outside

the group sessions as the 'therapeutic' boundaries are kept less rigorously in the groups. Family therapy is also recommended as mother's breast cancer may often have a greater impact on the whole family dynamics, either the family members becoming too overprotective towards the patient or withdrawing themselves from her (Schoenberg, 2007). This kind of situation will make the patient feel even lonelier with her illness. Stress management skills were effective in reducing overall distress amongst cancer patients (Aguero-Trotter, 2005) and the use of a short-term psychological intervention, called 'stress management training', was successful in reducing depression and fatigue in the post-surgical period (Garssen et al., 2013).

McArdle et al. (1996) indicated that hospital-based support, offered by a nurse specialist in the peri-operative period, significantly reduced psychological morbidity, as measured with self-rating scales by women undergoing surgery for breast cancer. However, an interesting point here was that community-based support provided by a voluntary organisation for discharged patients, failed to offer this kind of improvement. Based on these results, the authors highlighted the importance of establishing rapport with patients already during the initial crisis of diagnosis and treatments. Quality of life is an important factor in survivorship (Kwan et al., 2010) and higher levels of social support were associated with higher quality of life whereas younger age and later stage at diagnosis lowered the quality of life satisfaction. Similarly, and in line with these results, early-stage breast cancer survivors with low social support and worries about illness progression, may experience poorer quality of life, lasting for several months (Waters, et al. 2012). Thinking about the close link between mind and body, a breast cancer patient's quality of life also includes her general physical wellbeing, side by side with her psychological welfare. Kärki et al. (2005) carried out a series of studies which indicated an urgent need for developing systematic rehabilitation protocols for breast cancer patients in order to support their daily functioning and to prevent permanent limiting disabilities that may affect their quality of life and obviously, in a long-term run, their mental health.

Many authors have highlighted the importance of acknowledging the patients' phantasies linked with their illness. Postone (1998) proposed that encouragement from the other people to have a 'positive outlook' might easily lead to a situation where the patients are reluctant to express their negative feelings with the fear that talking about them will worsen their illness. In contrast, being able to address the difficult feelings and to explore the more unconscious meanings of the illness, should be essential. This kind of 'open' approach will help to reduce 'double suffering'; this means that the patient is not only suffering from the actual physical illness, but she is also suffering 'silently' from different, often difficult feelings linked with her underlying phantasies about her illness. In their literature review of illness perceptions linked with breast cancer Kaptein et al. (2015) suggested that helping patients to replace their unhelpful ideas about their illness is instrumental in improving their overall quality of life.

Likewise, encouraging the patient to reveal her phantasies about her illness, will often uncover clues about the psychodynamics of the patient's life narrative (Kent & Blumenfield, 2011). Therefore, helping the patient to understand her phantasies might greatly aid in relieving her anxieties and depression. The authors concluded that 'psychodynamic life narrative' can help the patient to come to terms with the meaning of her illness in the greater context of her life. Cancer patient's dreams may be closely linked with her physical condition and can be helpful in understanding phantasies linked her somatic illness (Calogeras & Alston, 2000). The use of the internet in the lives of women with breast cancer, concluded that narrating through the online space has significant positive consequences for the patients' ability to cope with their illness (Orgad, 2003). This may well be linked with sharing similar kinds of experiences with other women in the same position.

Rodin and Zimmermann (2008) have tried to find some positive consequences linked with the situation where the person has to face a potentially life-threatening physical illness. For many, the authors suggested, a serious illness will precipitate a developmental crisis, which may or may not be fully resolved but which will bring at least a possibility for creative change and growth. The assault on the 'self' will evoke a heightened need for self-delineation and recognition. Therapists working with seriously ill patients become implicated in the most profound questions related to the human condition, like the meaning of life, the fear of suffering and the problem of living in the present while facing the certainty of death. A review of 134 empirical studies assessed relationship between breast cancer and positive functioning (Casellas-Grau et al., 2016). The results showed that being young, undergoing chemotherapy and having social support were associated with well-being, post-traumatic growth and finding benefit and meaning in one's life. The cultural factors and positive personal characteristics, like optimism, had an influence on women's coping styles. Socio-economic status and level of education were also linked with positive psychological functioning. Baize et al. (2008) saw the psychological impact of breast cancer diagnosis as double sided. Firstly, it is linked to the bad image of cancer meaning suffering and death. Secondly, it is linked to the good image of breast, symbol of femininity, sexuality and maternity. The authors suggested that bearing in mind these two components could allow professionals to optimise information, listening and help.

Postone (1998) pointed out that although psychodynamic psychotherapy is a valuable intervention for many cancer patients, this modality has been under-utilized because psychotherapy with medically ill patients has been historically linked to working with patients who suffer from psychosomatic illnesses. This kind of too sharp and rigid distinction made in the literature between psychosomatic and physically ill patients, has led, to a situation where psychological help offered to physically ill patients has been almost exclusively limited to a supportive and/or educational kind of approach. Psychodynamic psychotherapy with cancer patients, the author underlined, is obviously different from psychotherapy with traditional psychosomatic patients. The issues involved with

cancer patients concentrate on the emotional impact of dealing with a real life-threatening physical illness and the consequences of treatments which can produce extensive side-effects. Parkinson (2003) emphasised that we are dealing here with two realities; that of the illness itself and its physical effects, and that of the patient's emotional state and inner world. Psychodynamic psychotherapy can be particularly useful for those patients whose illness has triggered intensified intra-psychic conflict (Postone, 1998). An important goal in this approach is to reduce the suffering by exploring the individual's distressing phantasies. It is important to assist patients to understand the specific meanings which they have attributed to their illness and to which they are reacting. Exploring these phantasies will thus become a major focus of ongoing therapy and when understanding is achieved, the 'silent' suffering which had been intensified by these unconscious meanings, may well be reduced.

2.5. Focussing on my Research

My literature review helped me to shape and identify the goals of my study. As I have mentioned before, the psychoanalytic research made in the area of breast cancer was conspicuous by its relative absence (apart from some case studies). So, my aim was to start to try to understand women's excessive distress from a psychoanalytic perspective. Interestingly, some non-psychoanalytic studies gave me indirectly hints that I was focussing on the right direction. Previous non-psychoanalytic research had already concluded that the high psychological morbidity could not be fully explained from the current situation (the state and prognosis of the physical illness). Some recent studies had suggested a link between excessive distress in a current physical situation and some more obvious past experiences in a woman's life; for example, adverse childhood experiences such as neglect and maltreatment. However, these studies had not elaborated these connections any further. I intended that my study would concentrate on these issues, but at a different psychological level, because I was linking these connections more on underlying, less conscious reasons in women's life. I wanted to explore the seemingly disproportionate emotional distress from a psychoanalytic point of view. It was my hope that my findings could be utilised in a clinical setting and that the professionals might then understand their breast cancer patients' distress from perspectives that they and their patients had not previously been conscious of.

3. METHODOLOGY

3.1. Qualitative Research Methodology

In my study I conducted qualitative research methodology drawing on the psychoanalytic interview method and psychoanalytic metapsychology as a way to understand how human mind works. Before discussing the psychoanalytic research method in more detail in this first section, I will present some reflections, related to my own approach, about the qualitative research methodology. The qualitative research has been very popular for a long time in the social sciences and interdisciplinary development has made the social sciences closer to the humanities where research uses the theory and methodology of interpretation as well as narrative, discursive, conversational and linguistic forms of analysis. Kvale (2003) made an interesting observation that the discipline of psychology had until about that time, remained outside of qualitative research. He found that discovery rather odd because the main methods of psychology, such as gaining information from interviews, happen through human relationships. Nevertheless, alongside the traditional social sciences, the qualitative methods are nowadays widely used in disciplines with different kinds of outlooks, such as psychology, anthropology, ethnography and literature (Midgley, 2004). The data in qualitative research is often collected from participant observations or in-depth and relatively unstructured interview methods and it is most often in a form of language. An integral part is the researcher's engagement with the research subjects and its primary objective is to gain knowledge from their viewpoints. The samples are usually small. The researcher is trying to discover underlying issues in what participants are expressing; the emerging hypotheses and theories are grounded in the data itself, as for example in grounded theory and phenomenological analysis. The generalisations, formed in this way, are based on individual experiences (Midgley, 2004; Mauch & Park, 2003).

Face-to-face interviews have probably become the most common type of qualitative research method in social and behavioural sciences when finding out about people's experiences in different contexts and the personal meanings they hold (Kvale, 1990; Hollway & Jefferson, 2008). The nature of qualitative research is to try to discover 'emotionally' the ideographic features of research subjects; to understand participants' individual perspectives and their experiences in the particular social contexts. However, the assumptions and methods for appropriate qualitative research are still far less known and agreed (Wallerstein, 2009). Criticism has been raised that most of the new qualitative methods, such as discourse analysis and narrative analysis, continue to treat their research subjects as a rational and integrated group, expecting that the participants do not have any emotional obstacles in remembering difficult experiences of their lives. Some researchers, such as

Hollway and Jefferson (2008), have turned to psychoanalysis to find a remedy for that kind of situation.

There is a disagreement amongst qualitative researchers in social sciences how to make use, or not to make use, of psychoanalytic theory, the aims of which are in many ways similar to social research when trying to understand people's individual perspectives and their experiences. For example, this internal conflict can be seen between Parker (2004) and Hollway & Jefferson (2008). Parker claimed that focusing on the unconscious processes, will create a risk of overlooking social conditions, whereas Hollway and Jefferson valued the importance of concentrating more on research participants' subjective experiences. In the following sections I will focus on the psychoanalytic method where the individuals' subjectivity and unconscious processes have a significant and central role.

3.2. The Psychoanalytic Method

In the following chapters I will first describe the historical developments of psychoanalysis as a method of treatment and discuss the criticism psychoanalysis has received. Following that I will review psychoanalysis as a research method and in the end explain some of the main features in psychoanalytic research; namely the psychoanalytic interview, the free association method and the psychoanalytic qualities of the researcher.

3.2.1. The Historical Development of Psychoanalytic Treatment Method

As the psychoanalyst and philosopher Brearley (2000) has pointed out, Aristotle once said that there is no such thing as absolute certainty, only the certainty that befits the subject; what is certain or accurate for the carpenter, is not certain or accurate for the physicist. Aristotle meant by this example that the kind of verification appropriate for a statement about human emotional reality is different from one which would be appropriate for a statement, about a physical body or a sociological trend for example. Aristotle stated that if there is no single common method by which we may discover what a thing is, then the treatment of the subject becomes more difficult as we will have to find the appropriate method for each subject. Brearley (2000) continued that psychoanalysis, more than any other relatively systematic set of ideas about people, takes serious account of the unconscious dimensions of thinking, emotion and action in a way that does justice to the realities people are concerned with in their personal and inter-personal lives. It is an 'appropriate method for its subject'. This conceptual depth makes possible a fuller theoretical understanding of people and their

development; the methodology of the psychoanalytic treatment setting and process is designed to make this possible in practice.

Freud's clinical work and his self-analysis, especially his dreams, were the main basis on which he gradually conceptualised his psychoanalytic theories and psychopathologies, especially his case studies. Midgley (2006) has pointed out that the clinical case study, as a specific form of psychological research, was already a well-established method. It was going back as far as Pinel's little stories, 'historiettes' in the early 1800's (Goldstein, 2001) when Freud and Josef Breuer published their 'Studies on Hysteria' in 1895. However, compared with the previous case studies, Freud's analyses differed by the depth and intimacy with which he described his patients' inner lives. (I would like to comment that nowadays 'hysterical' is often used in a disapproving way, but the diagnosis of 'hysteria' was a common one in Freud's time and did not have the same negative connotations.) Some of the most well-known of Freud's case studies are the following: 'Anna O', who had been Breuer's patient and was described by him as 'having psychosis of a peculiar kind' whereas Freud concluded that the root of her hysteria originated in her childhood sexual experiences (Freud, 1955a [1893-95]). When treating 'Dora', Freud obtained an understanding of her symptoms of hysteria mainly by interpreting her dreams (Freud, 1953 [1901-5]). In 'Little Hans' he realised that the boy's phobia of horses was a displacement from his rivalrous hostility towards his Oedipal father (Freud, 1955b [1909]). The 'Rat Man' suffered from obsessional neurosis torturing himself with the fear of being punished by rats as a result of his sexual wishes (Freud, 1955c [1909]). The 'Wolf Man' was tormented by a frightening dream of wolves which Freud linked with his childhood neurosis after he had witnessed sexual intercourse between his parents (Freud, 1955d [1917-18]). Furthermore, Freud thought that in 'Schreber's' case he was suffering from paranoid schizophrenia which was related to his repressed homosexual fears (Freud, 1958 [1911-13]). It is important to understand that Freud used his psychoanalytic treatment method, not only to cure his patients, but also as a way to gather new theoretical knowledge and to confirm or modify his already discovered ideas of a psychoanalytic understanding of the mind.

Freud assumed that all human behaviour was ultimately understandable and that it followed rational laws. The laws can only be seen as rational if we understand the principles that guide them (Roth, 1999). Crucially and centrally, Freud added two essential hypotheses, the idea of psychic determinism and the idea of unconscious processes when understanding human behaviour. Our unconscious feelings and thoughts often influence very powerfully our behaviour though most of the time we are not aware of that. Revolutionary in its own time, Freud's book 'The Interpretation of Dreams' in 1899 showed how the unconscious manifests itself in our anxieties, physical symptoms and dreams. In the years following Freud's pioneering work, psychoanalysts have studied different aspects of the human mind and all this knowledge and experience is applied to the psychoanalytic

treatment method. Freud understood how children and adults may suffer from psychological problems if they can't talk about painful matters or if they can't make sense of them. The analytic relationship in a trustworthy atmosphere allows difficult and mainly unconscious experiences and processes to be safely explored and understood, and as a result of this kind of arrangement people will have a chance to grow. For many people their childhood home provides such a setting for psychological growth, but for many others, for various reasons, this kind of provision is not sufficiently available. That is the time when we need further help for our lives to become more rewarding. Psychoanalysis is a highly effective treatment method that can improve the lives of many people. It can help us to better understand ourselves, to work through our difficulties and recognise that our complex and often unconscious emotional life is a fundamental part of being human (Psychoanalytic Help. The Institute of Psychoanalysis, 2015).

The psychoanalyst's clinical consulting room is the place where psychoanalytic 'discoveries' are made (Rustin, 2003). The physical and psychological 'setting' is of paramount importance for detecting and understanding how the patient's mind works, especially her more unconscious parts of it. The 'setting' means a fixed arrangement, agreed by both parties; the sessions, each lasting for 50 minutes, take place regularly in certain weekdays and times and in the same room which is protected from external disturbance. Psychoanalysis happens 4-5 times a week whereas less intensive psychoanalytic psychotherapy 1-3 times a week. The treatment is usually open-ended, and the constancy of setting assists in 'holding' the patient. The couch is usually used in analysis because lying down without having direct eye contact with the analyst, helps the patient to free associate, to say whatever comes to her mind. In this way, more unconscious material will emerge. The unconscious not only expresses itself through the process of free association but also in dreams, slips of tongue and in the patient's transference relationship to her analyst. The psychoanalytic method of listening to the unconscious, concentrates on these elements.

Not seeing the analyst helps to develop transference and countertransference phenomena which are very important tools in understanding the patient's more unconscious feelings and thoughts. In transference the patient transfers onto and into her analyst feelings and thoughts which belong to her relationships with other important people in her life, usually her childhood figures. The patient is repeating, instead of remembering but with the help of the analyst's interpretations, she can become aware and understand how these past issues of her life have an impact on the present. In this respect it is important that the analyst keeps her neutrality, not sharing her own personal life with the patient. Otherwise the patient's life is at risk of being mixed up with the analyst's life. In the same way as the scientist would not contaminate the 'laboratory feel', the psychoanalyst would not contaminate the 'transference feel' by talking about her own personal issues. Countertransference refers to unconscious and conscious responses and feelings to the patient's communications which

need to be disentangled by the analyst from her own personal responses. The analyst's countertransference experience is an important source of evidence for her about the patient's past experiences and their impact on the patient's current functioning. The analyst exclusively focuses on the patient's communications where certain themes may be repeated. In this way the patient's internal world becomes available for reflection and provides a creative process for the patient and analyst to explore together. It is important that the analyst uses her patient's language, the patient's own words without changing them much, as this will help not only the patient to feel that she is being understood, but also that the analyst keeps her neutrality, keeps aspects of herself out of the situation. It is also essential that the analyst listens and understands the individual patient but at the same time she needs to take a step back and ask from herself how she can understand this particular patient using her own knowledge of psychoanalytic theories. In this kind of way, it will be possible to observe unconscious processes.

It takes many years to become a psychoanalyst. The basic requirement is being a university graduate but many trainees in the British Psychoanalytic Society are also psychology or medical practitioners or they may come from careers in mental health, teaching, law, the arts as well as the media and finance. Most of the candidates would have had clinical experience of some kind and it is normally required that the applicants have had prior experience of personal psychoanalysis or psychoanalytic psychotherapy before they apply for the full training. Infant observation where the student gets experience of being an observer in a situation where a mother is with her baby over a year or so, is also a part of preparation for the start of the psychoanalytic training. The training is made up of three components; a personal training analysis, a series of theoretical and clinical seminars, and the supervised psychoanalysis of two patients. The minimum time to finish all these components is four years but for many candidates the training will last longer (Psychoanalysis. The Institute of Psychoanalysis, 2015). After this basic training the person may have further training to receive the Fellowship of the Society and possibly some members may become later Training Analysts or Child Psychoanalysts.

3.2.2. Discussing the Criticism of Psychoanalysis

Most critics of psychoanalysis have adopted a single-minded view of science, assuming that its investigatory methods are uniform and invariant, whatever their object of study (Rustin, 2003). In the reality, the sciences are diverse in their methods because of the different kinds of phenomena they study, and each must establish its own appropriate method.

There are two major strands of criticism of psychoanalysis; one represented by Popper (1963) and the other by Grunbaum (1984). In Popper's view psychoanalysis proceeds by seeking out

verifications for its theories, and its claims are immunised against any testing. They are not falsifiable. By the term 'falsifiable' Popper meant that a theory should be open to testing and to the possibility that it might be wrong. In this way falsifiability allows other more accurate explanations to be considered and formulated. This in turn helps human knowledge to progress. However, Grant and Harari (2005) proposed that Popper's description of psychoanalysis as a pseudo-science is based on his misunderstanding of it. They disputed that Popper's argument against psychoanalysis is logically flawed and empirically false. Furthermore, even if Popper's definition of science is accepted, there is considerable clinical, experimental and neurobiological research in psychoanalysis which meets Popper's criterion of a science. Grant and Harari (2005) concluded that attacks on psychoanalysis based on Popper's theory of science, are ill-founded and reflect inadequate scholarship.

Popper's (1963) approach emphasised that in the empirical domain, nothing can never be proved to be true. Even though we have observed many similar kinds of phenomena that seem to fit a theory, further phenomenon may not fit. So, there is no such thing as absolute proof for theory. For Popper, 'good' science allows its theories to be falsifiable and rejected. Thus, something that is never false, is unscientific or pseudo-science. Popper stated that Freud's theories were that the past explained all the present clinical phenomena including unconscious conflicts. Popper claimed that Freud was not interested in any other perspective and therefore psychoanalysis for Popper was a pseudo-science as it did not try to falsify its theories with truly scientific experiments.

Popper's (1963) criticism stems from what he regarded as Freud's inductive method, discussed by Hume (as cited by Howson, 2000). Induction is a method of reasoning that moves from specific instances to a general conclusion. The generalisation is then meant to apply to all instances. On the other hand, deduction is a method of reasoning which moves from generalised principles that are thought to be true, to a true and specific conclusion. It starts with one or more statements (premises) and uses logic to reach new conclusions based on those statements. Popper claimed that the way one obtains ideas, from experimental data or otherwise, is not a solely logical process; it is often inscrutable and incomprehensible. He proposed that the best procedure was to use one's imagination in order to select a hypothesis and then logically to deduce the consequences for scrutiny in comparison with existing and future experimental data, using critical analysis. This procedure is known as the hypothetico-deductive method. Popper pointed out that new observations which falsified the theory, would in principle lead to a logical step forward by requiring a new theory to be formulated. Therefore, his advice was that scientists should try to falsify their theories in order to make progress. However, Popper's contemporary Michael Polanyi argued that induction undeniably remains a valuable and principal source of information that has led to the formulation of many successful theories (Polanyi, 1958). Freud's theories are one example. Polanyi re-established

induction, derived from experimental or observational data, as an important source of hypotheses for subsequent evaluation, using Popper's hypothetico-deductive procedure.

As I will show in the following, Freud used both induction and deduction in his work. He used induction to derive his theories from his work with his patients, his self-analysis and cultural phenomena. In the case of his theory of the death instinct, he speculated in much the way that Popper advised. However, clinically Freud worked, as psychoanalysts still do, using deductive model, with general hypotheses (including the hypothesis of psychic determinism) to understand his patient's material as it unfolded. Although no prediction was involved, material which did not fit in Freud's working hypothesis, asserted itself and it was used for amending and developing his theory. This process is an instance of what Polanyi (1958) thought of as 'serendipity' (the fact of finding interesting or valuable things by chance, when one is not looking for them) and it is a good example of how nature and experience continuously intervene to control the direction of scientific progress. As Anderson (1999) has pointed out, 'serendipity itself does not contradict the Popperian principle about the theoretical content of observations because, as Pasteur long ago pointed out, such discoveries come to minds prepared for something else'. Serendipity also shows, as Polanyi emphasised, that successful science is very far from a solely formal and logical pursuit of knowledge. The consulting room is the psychoanalyst's laboratory where data can be accumulated and may confirm or falsify his/her theory. In the process of theory formation Freud, like Popper, always regarded his theory as a set of provisional hypotheses, and they were subject to correction and revision in the light of new clinical data. In this sense, at the level of metapsychology, Freud employed informally a method akin to Popper's hypothetico-deductive method.

Yorke (1995) has underlined that for Freud the clinical observations in psychoanalytic treatment situation, were the bedrock on which his meta-psychological abstractions were firmly rooted. Metapsychology, after all, was only another word for Freud's theory of mind. It is important to note here that Freud himself did not hesitate to change his models based on his earlier clinical findings in the light of his new clinical experience, such as for example the addition of the structural model of mind (ego, id & superego) to his topographical model of mind (conscious, preconscious & unconscious). Another example of this is his earlier hypothesis that a repressed memory of an actual earlier childhood sexual abuse was the cause for his patients' neurotic problems. However, he abandoned this theory after researching the topic further in his clinical work and concluded that his patients' childhood revelations were sometimes based on their childhood sexual phantasies and did not always stem from actual sexual experiences. In this way, we could see, how in Freud's work the clinical and theoretical aspects were continuously interacting with each other. As discussed by Brearley (2000), Freud held it to be essential for progress that his ideas should be open to constant criticism and revision.

Grunbaum (1984) took a different approach. Instead, he argued that the subjectivity of the clinician's mind and her interpretations will influence the validity of her clinical findings. In Grunbaum's opinion, their validity cannot be then tested. His emphasis on the importance of the psychoanalyst's use of her own subjectivity in clinical work is appropriate. However, his understanding of the role of subjectivity generally in science and particularly in psychoanalysis, is open to challenge. Here I return to Polanyi (1958) whose theory of 'personal knowledge' is helpful. Polanyi saw that such personal knowledge is inevitably involving the epistemic standpoint of the investigator (her relation to the knowledge itself), in contrast to knowledge which is traditionally conceived as objective and independent of any personal aspect. Polanyi's views differed from Popper's views because he is stressing the additional importance of informal procedures within science, and in this way, he differs from Grunbaum too.

For Polanyi (1958), personal judgements of individuals were guided by the tacit and explicit forms of their relevant knowledge, accumulated during their lifetime experiences. Polanyi argued that the personal participation of the individual is involved in all acts of understanding and does not make our understandings necessarily subjective, because comprehension is not an arbitrary act. 'Comprehension', he wrote, 'is neither an arbitrary act nor a passive experience, but a responsible act claiming universal validity. Such knowing is indeed objective in the sense of establishing contact with a hidden reality (universal laws); a contact that is defined as the condition for anticipating an indeterminate range of yet unknown (and perhaps yet inconceivable) true implications' (Polanyi, 1958). To count as knowledge, it must be possible for assumptions to be false. In his complex account of the role of the personal in science (and all other disciplines) Polanyi does not intend to contradict the widely-held view that a special feature of science is its capability of producing, perhaps uniquely, what others describe as objective or, perhaps better, reliable knowledge (Ziman, 1978).

By acknowledging the subjectivity of the psychoanalyst, Freud did not mean to diminish psychoanalysis as a source of reliable knowledge about the human mind and its functioning. Therefore, he stressed the importance of neutrality in the psychoanalytic method and emphasised the need for the analysts themselves to be analysed in order to minimise obstacles to objectivity and neutrality (Baker, 2000). Freud underlined the training as a foundation for a person to be expert in conducting psychoanalytic research. I understand that total neutrality is impossible for any of us as we are not functioning as robots, but the most important thing is to be aware of our own personal attitudes and feelings. Psychoanalytic training and especially its understanding of the transference and countertransference issues (which I have explained earlier), are very essential in keeping our professional stance but simultaneously using our own subjectivity when trying to understand another human being. The use of subjectivity in psychoanalysis, understood in this way, is often misinterpreted by its critics – an example is Parker (2004) who seemingly unaware of Freud's views

on neutrality warned negatively against the risk of losing a 'neutral' stance if the psychoanalytic thinking 'gets a grip on you as a researcher or on your participants'.

There is a tendency amongst the critics of psychoanalysis to concentrate on Freud's primary discoveries or theoretical principles without realising that psychoanalysis has developed considerably since. A demonstration of this development is 'applied psychoanalysis' where psychoanalytic ideas have been utilised in different disciplines such as working with families, understanding works of art and psychological aspects in physical illnesses (as I have done in this research). Another example of this development is neuro-psychoanalysis (Kaplan-Solms & Solms, 2000) which confirms Freud's basic hypotheses of mental functioning. Lacewing (2013) argued that contemporary developments in the methodology of psychoanalysis are sufficient to secure the scientific status of accounts regarding the motivational structure and complex mental processes involved in defence. Lacewing (2013) has defended psychoanalysis by stating that it has moved from its original 'economic' model, developed by Freud. It is a process of self-reflections, self-interpretation and self-formation. This process can be transformative by opening new ways of understanding ourselves and the meanings of our behaviour, providing insights into previously unrecognised motives.

Psychoanalysis presents us with a general theory of motivation, character, interpersonal relations and aspects of mental functioning, which is comparable to other such theories in empirical psychology. Its scientific status has been underpinned by neuroscience (Solms, 1995) and its interdisciplinary nature has always gone beyond clinical observations to obtain data from other research disciplines. On the other hand, psychoanalysts have been active in producing research evidence for example in areas of child development and psychiatry. This kind of interactive approach has been also supported by Eagle (2007) who sees the future of the discipline of psychoanalysis being in its openness and receptivity to relevant findings from a variety of other disciplines. This will strengthen psychoanalysis as a science in its own right. Jalal, Settlege and Ramachandran (2014) suggested that a scientific psychoanalysis will have a more solid framework in the future if it can explain more thoroughly phenomena such as subjective experiences, inter-subjectivity and mind-body interactions. However, the science should not exclude a hermeneutic-based psychoanalytic clinical practice that needs to coexist as an important source of ideas and hypotheses to be further explored. Links with the 'outside world' relates the psychoanalytic research very firmly to the qualitative research methodology.

Freud did not see himself as a guru, nor psychoanalysis as a religion. Central to psychoanalytic thinking is the concept of unconscious. Freud did not invent this idea, but he was aware of it being present in different areas of life, as for example in art and literature (Madonna and child paintings,

Sophocles, Shakespeare). He gave the unconscious a place in the psychoanalytic theories as to how the human mind works. Likewise, the Nobel winning scientist Eric Kandel (2012) has recently described developments in our understanding of the unconscious across art, literature and science to the present. Brearley (2000) suggested that if a person totally lacks the concept of unconscious, his then acquiring it would be like coming to understand the notion of three-dimensional space, instead of living in two dimensions. For most of us, it is not faith which we require but reflection on and extension of what we already are capable of knowing. One's own self-deception is almost always the hardest to recognise, for reasons that psychoanalysis makes clear, because much of the truth about ourselves is often painful.

3.2.3. The Psychoanalytic Research Tradition

In this section I will show that the psychoanalytic research method is appropriate for its field of investigation. As I have already highlighted, psychoanalysis is not only a method of treatment but also a method of research. The consulting room setting with its controlled conditions is similar to a 'laboratory' setting and this room is the main place for the research to happen. As described before, psychoanalytic research started from Freud's single case study method and it was seen as a primary modality for discovering the unconscious mind. During this early period, most of the key questions and concepts that still form the basis of psychoanalytic theory, were 'discovered' (Rustin, 2003). For Freud, the new discipline of psychoanalysis was to conform to the requirements of a natural science. Freud's approach was novel as he developed an operational tool how to study psychological causal sequences and how to mobilise repressed unconscious material in the therapeutic situation. This allowed him not just generally and theoretically to postulate the concept of unconscious but also study empirically how it influenced his particular patients' behaviour and physical manifestations (Alexander, 1962). As a neurologist himself and with his model of psychic energies, Freud tried initially to understand human psychology in terms of the principles of the day, such as neurological excitation and biological laws of homeostasis (Lacwing, 2013). So, psychoanalysis at the time of Freud's early investigations was a biologically and cognitively based natural science. However, Freud was also clear that there were limits when attempting to bring objective scientific methods to the field of psychoanalytic investigation as research will never provide us with absolute certainty. In his letter to Marie Bonaparte (his colleague) Freud wrote that the 'true scientific minds' can endure doubt, they have both the freedom to create and discover but also the discipline and patience to rigorously challenge and investigate (Midgley, 2006).

The present-day question about what kind of science psychoanalysis is and what kind of research is appropriate to it, has led to diverse, complex and contested positions over many decades (Wallerstein, 2009). However, the credibility of psychoanalysis as a discipline has survived many

challenges and its status as a science has been increasingly accepted. Even though Freud's tradition started from a neuroscience perspective and currently, there is an upsurge of neuro-psychoanalysis, the discipline of psychoanalysis is nowadays mainly understood as a behavioural and human science. As Wallerstein (2009) has explained, psychoanalysis is a behavioural science, committed both to the elaboration of general laws of the mind and to the specific ideographic features of each individual being studied. Conceptual psychoanalytic research makes psychoanalytic concepts themselves the objects of research, whereas empirical psychoanalytic research uses psychoanalytic concepts when it is searching for psychoanalytic propositions. In empirical research the investigation is systematically planned, it has got a clear design and it takes place 'extra clinically', outside a consulting room setting (Wallerstein, 2009). Cartwright (2004) has criticised that the therapeutic aims have often been dominating and little progress has been made in the past to develop suitable psychoanalytic research methods. Relevant research methodologies from other disciplines, from social sciences for example, could be helpful in measuring therapeutic outcomes in the future.

However, the contemporary clinical psychoanalytic research method is well adapted to study the variety of unconscious states of mind (Rustin, 2003). Psychoanalysis does belong to the human and social sciences and the way how it describes and understands the human mind, has similarities in many respects with the arts and humanities. All these disciplines give an important role to 'subjective meanings' when individuals are describing their experiences. However, psychoanalysis also shares the attributes of system, logic and critical attention to facts. These are the attributes belonging to the natural sciences. Knowledge in psychoanalysis has accumulated in 'logical' and accountable ways, in the sense that successive advances in theories and techniques have been explicitly built on earlier discoveries in the evolution of ideas. In this way contemporary psychoanalysis has kept links with its scientific origins but at the same time it has also sought to protect and nurture the understanding of individual mental creativity of its subjects and its practitioners. Researchers have been looking for methodologies that are able to retain the specificity and complexity of the therapeutic process but at the same time to offer a systematic way of approaching data (Midgley, 2004). 'Consulting room methodology' which supports openness and spontaneity could be also applied to psychoanalytic research (Rustin, 2003). Risks might arise if the researcher has got too narrow an idea of what she is looking for and where the discoveries are presumed to be. Furthermore, Rustin states that the development of more formalised empirical methods, such as replicable systematic coding procedures, blind rating and audio video-recording for example, may jeopardise the essential openness. Certainly, there are research projects where these procedures are useful and needed but here Rustin (2003) is just warning that if the openness and spontaneity are downgraded and the 'tools' become more important than the work we are aiming to do, then aspects of the human subject that we are studying, might escape from our view.

The clinical case study is a foundation for psychoanalytic research, and it remains the most widely used and accepted method in present-day clinical research. It provides 'evidence' and 'clarification' of certain theoretical ideas already held or it may lead to the development of new ideas (Midgley, 2006). In this way the case studies give an opportunity to integrate our own clinical experience with theoretical concepts. Furthermore, the case study will allow readers to get a sense of what goes on in the private space of a clinical treatment. The single case studies are often the most relevant way of studying causal influences and mechanisms and they are a good basis from which to move towards a wider level of understanding. In this way they are helping to bridge the gap between research and clinical practice. As Midgley (2006) and others (for example 'Case Study as a serious Research Strategy' by Yin, 2016) have shown, the case study has been accepted as a robust research method.

Despite of all its strengths, the case study method has been criticised as a form of reliable research. I want to point out here briefly some of the issues that case studies are criticised for. Following Midgley's paper (2006) the collected data in a single-case study has been claimed to be unreliable as it is mostly gathered retrospectively. However, all qualitative interviewing is retrospective in a sense that people are asked to memorise and recall when they are invited to focus on their past experiences and describe them. Furthermore, it is argued to be often unclear what is the therapist's account and understanding, and what actually happened in the therapy session. Using video or audiotape for recording the sessions may be one answer but this kind of practice has been traditionally opposed by clinicians as it is felt to be an intrusion on both patients and psychoanalysts or psychotherapists. It is against the fundamental principle of the treatment; namely, the exclusion of any audience. However, using a recording device could help to separate the clinician's role from that of the researcher and subjective distortions in data collection may be avoided. However, a problem with this approach is that there could be a danger of getting lost in detail and being unable to perceive the bigger picture. Moreover, the recordings may fail to capture the very essence and important part of the psychoanalytic theory, namely the 'psychoanalytic listening'. It is very difficult to record what goes on internally in the patient's and her analyst's mind.

The 'psychoanalytic listening' means that the analyst allows herself to be in a state of 'free floating attention' where she is in touch with her own unconscious when listening to her patient's unconscious communications, free associations, dreams and transference and countertransference issues. This kind of listening skill is gradually achieved in the course of training and the major component helping this development, is the trainees' experience in their own analyses. The analyst needs to listen beyond the frontiers of consciousness with the whole of himself (Robinson, 2015), in this way keeping himself totally receptive to his patient's communications. As Freud expressed it in his famous dictum, the analyst 'must turn his own unconscious like a receptive organ towards the

transmitting unconscious of the patient. He must adjust himself to the patient as a telephone receiver is adjusted to the transmitting microphone' (Freud, 1958 [1912]). Recordings could not pick up the interiority of this listening, including transference and countertransference issues. Furthermore, writing notes at the same time would most probably disturb this kind of listening and most analysts tend to write their notes soon after seeing their patients when the material is still fresh in their minds. In the consulting room setting the analyst will gather together the results of listening to form hypotheses as to how the patient is functioning. She will then test out her hypotheses by offering interpretations to her patient in a thoughtful and well-timed way. The second area of criticism has been directed against the analysis of data as the clinical case study researcher usually selects and interprets material which fits in with her own theoretical preconceptions. I doubt whether there is any solution to this 'problem' as the relationship happens between two human beings and one relationship is unlike any other. Every analyst is an individual with her own personality and professional interests but perhaps the most important point here, I think, is again that the analyst needs to be aware of the transference and countertransference issues which will help her to hold her own professional stance. In my research, I have asked a colleague to check my results and totally independently, she has come to very similar conclusions.

Midgley (2006) noted that the process of discovery in psychoanalytic research has some similarities to the method of 'grounded theory' developed by Glaser and Strauss (2017) as well as possibly to some other qualitative methodologies in social sciences (content, thematic, discourse, conversational, narrative analyses). He also stated (referring to Edelson, 1985 & 1986) that hypotheses for certain psychoanalytic ideas could be tested in a single-case study and quantitative approaches would be possible (referring to Fonagy & Moran, 1993) because numerical representations may help in reducing the complexity of some observations. The last criticism of single case studies is related to their generalisability. The researchers are ultimately not just interested in a particular individual but want to be able to generalise their discoveries to a wider population. One option, which I have used in my research, would be to make a group, rather than the individual, as the primary focus of research. The other option would be to replicate systematically a single-case study with other individuals. This method can help us to understand what aspects of the original study's findings are transferrable to others, but also those that are not. Using more specific principles of case-selection for these kinds of 'aggregated single-case studies' would gradually help us to establish how far, and in what kind of ways, the findings of any one case study can be generalised to others.

Single case studies are based on psychoanalytic treatment. I did not have patients in treatments but even if I had been in that kind of situation, presenting patients in this kind of forum may have posed problems of confidentiality. So, instead of doing a single case study in a traditional way, I had chosen

to investigate a group of individuals and in this way, I extended the psychoanalytic study outside the consulting room. I also prepared a short case summary of each individual woman even though my main focus was to study different women's psychological reactions to the illness process in four consecutive individual interviews. This model made it possible for me to explore whether there were any less obvious underlying unconscious reasons for the ways that different women were coping with their illness and whether there were any general hypotheses to be made. I have understood that my approach was novel in a sense that I wanted to concentrate on this whole essential phase of a woman's life as a breast cancer patient. My approach was time orientated as I followed the woman through her illness, and original as I tried to understand the underlying, less obvious reasons for any level of distress I found. My intention to look at the meaning of the underlying psychological issues, in order to explain the level of distress, was also something new that I had not come across when doing my literature research. These topics will become clearer in the following pages where I will be showing my approach 'in action' when discussing my data.

3.2.4. The Psychoanalytic Interview Method

Applications of psychoanalytic theory can be used outside the clinical setting. Cartwright (2004) has shown how psychoanalytically informed interview techniques can lead to valuable material for a particular psychoanalytic research topic. When using this kind of meaning-centred approach, important information can be captured in the space of a few interviews about unconscious phantasies, object relations, pre-dominant defences and symbolic meanings through analysing participants' narratives as they are constructed around the subject of the interview. Significantly, the subjects which are being studied in this way, can be psychodynamics of everyday life situations. Such subject could be for example a serious physical illness and its impact on a person's psychological functioning.

Cartwright (2004) stressed the following points about the psychoanalytically informed interview:

1. The interview is pre-dominantly unstructured, focusing on all narratives that emerge from the topic of the interview.
2. The meaning given both to the interview context and the entire interview process are essential elements of the research interview.
3. The central aim is to utilise the psychoanalytic approach in the interview setting so that it can uncover unconscious meanings and intrapsychic processes (for example unconscious phantasies, object relations, defences and symbolic meanings).

It is important to emphasise here that a psychoanalytic interview is inevitably different from a psychoanalytic session as I have earlier pointed out. Psychoanalysis is a treatment method and the patient attends the sessions because she has got a psychological problem for which she needs help. However, in the psychoanalytic interview the researcher is interested in gathering together several participants in order to understand a particular research question. The central goal is to collect information around a specific theme and then to understand and interpret the meanings and intrapsychic processes in the collected material. Thus, the interviewer imposes a particular research topic of interest on an individual. So, it is the interviewer, rather than the interviewee, who brings to the foreground particular points which are related to the study, thus helping the participant to bring her associations and meanings to those themes. Even though free association is central to this technique (I will describe the free association technique in the next chapter), the interviewee cannot free-associate in the same kind of classical sense as in psychoanalytic treatment situation because the interviewer intends to focus on a particular area. But in the interview method there is still a certain freedom to free-associate and the theory will be allowed to develop from the person's narrative.

I want to emphasise that it is important here to keep in our minds that this kind of approach is not therapy but a method where psychoanalytic theory is used to understand patients' talking about their lives. This kind of method was going to be my framework for both the data collection and its analysis. In this approach, in my thinking, there are some similarities with grounded theory formation as the psychoanalytic understanding is gradually developed from the emerging material. Another possible similarity of psychoanalytic research session to grounded theory formation might be the emerging of repetitive narrative structures which mirror those more consistent and prominent factors that contribute to a certain individual's intrapsychic life.

Kvale (1990) indicated that the central aim of the psychoanalytic interview is that the interviewer is interested in bringing to the foreground particular foci related to the area of study to ensure that associations are organised around these points of interest. However, the interviewing needs to have an open mode; the participants can talk freely, rather than having to react to pre-determined standard questions. Nonetheless, the style of questioning is not totally non-directive. The interviewer has some theoretical ideas in her mind, related to the research topic. The questions are directed in a way that they could possibly help the participants to bring up the underlying meanings of the material, they are talking about.

So, the interviewer may have already developed some theoretical ideas in her mind when encouraging the participant to talk about, for example, a certain event in her life. The interviewer is then, by this time, making some assumptions after knowing, how this person has already reacted. Quinodoz (1994) has talked about 'Psychoanalytic clinical facts' by which he means fundamental

elements reflecting a person's psychic structure. These elements include the 'fact' of the unconscious, the 'fact' of the Oedipal complex and the 'fact' of repeating the infantile issues in one's adult life. It is important to understand that these psychoanalytic phenomena about the human mind arise outside the analytic situation and are a part of everyone's daily life which can be in this way understood in psychoanalytic terms. These phenomena are repetitive and observable. Psychoanalytic researcher can observe psychic events which are meaningful from her theoretical point of view when she is trying to understand the unconscious meanings of these events. In 'applied psychoanalysis' she may observe these events, not only in interview situations, but simply, for example, in the typical slips of tongue in people's everyday lives. She is also interested in 'clinical facts' when she studies the work of an author or artist. Different life events may have different kinds of unconscious meanings for the individual, even though she herself is not aware of that. A 'clinical fact' or phenomenon, such as losing one's breast, which is an event in external reality, may have a different kind of latent, unconscious meaning for different women. It might be linked in a woman's mind, for example, with her painful experiences from Oedipal period when she was a young girl, her parents had divorced, and she had lost the admiration from her father. This is an illustration where the loss of breast represents other losses in her life even though she is consciously not aware of that. However, she might become aware of that link when she is freely talking about her experiences in an interview situation. In this way external and internal reality are in a constant state of interaction and transformation.

It is crucial to understand that Quinodoz (1994) distinguished these more general everyday 'Psychoanalytic clinical facts' or phenomena from 'Proper psychoanalytic clinical facts' which belong only to the psychoanalytic treatment, either to psychoanalysis or psychoanalytic psychotherapy. The meaningful and problematic psychic events in a person's life will be then uncovered and interpreted during regular analytic or therapy sessions in the safe setting. In this way the patient can work through these issues in the transference/countertransference relationship with the analyst or therapist and not only understand them on an intellectual level. In a very similar way, Yorke (1996) has written about clinical observations in the consulting room. These observations are the basis for formation of clinical explanations from which clinical concepts derive. These concepts lead to explanatory theoretical concepts and into clinical theories which can be then used outside the consulting room, as in my research.

3.2.5. The Free Association Method

Freud who developed the theory of free association, compared it to a train journey. A traveller who is sitting next to the window of a railway carriage, is describing to someone else inside the carriage, the changing views which he sees outside (Bollas, 2002). All Freud did was to take a note of how

we, when we think by not concentrating on anything particular, are moving from one idea to the next one in an endless chain of associations. We create lines of thoughts, branching out in many different directions, thus revealing diverse unconscious interests. A discovery of psychoanalysis is that the strands of thoughts are usually linked by a kind of unconscious logic that is different, from say, the logical flow of giving a talk on a topic. The only logic of free association is that it is a form of unconscious thinking. This kind of reflecting is an ordinary part of our everyday thinking. We talk about what is in our minds, moving from one topic to another in a free moving sequence that may not follow an external agenda. Free talking is thinking out loud. We are the authors of our own meanings; we supply the meanings and this kind of self-discovery usually gives us pleasure.

In this kind of 'free' psychic movement in our minds, there are resistances against the return of unwanted, previously rejected/unacceptable ideas as well as defences we have built against mental pain. The psychoanalyst needs to understand and attend to these resistances and defences. If our conscious mind disagrees with too painful anxiety provoking ideas, these ideas will be repressed in the unconscious. Thus, free association is always a 'compromise formation' between psychic truths and the 'self's' effort to avoid the pain of such truths. The psychoanalyst tries to discover what the unconscious link between the elements of the chain is about. We communicate with one another unconsciously when we give ourselves over to the way how unconscious thinking takes place; through the free association of ideas that manifests a hidden order of thought. Bollas (2002) referred to Melanie Klein who noted that when we talk freely, we often seem to be talking about parts of ourselves and our internal relations. So, by free associating we sometimes are in discussion between various parts and functions of our own personality and our 'objects', the internalised others in our minds.

It is interesting to note that the traditional psychoanalytic method of free association has been adapted also by some researchers in social sciences. Hollway and Jefferson (2008) have developed a 'Free association narrative interview technique' emphasising that the free association method in the narrative can reveal significant personal meanings which were not necessarily obvious at the time of the interview. Hollway and Jefferson (2008) criticised the assumption of shared meanings between interviewer and interviewee in qualitative research. They state that this kind of approach relies on an assumption that the researcher knows, 'sees through', not only the participant's mind but also her own mind. In their view, this is, in the essence, the same kind of rational thinking that has been assumed by survey researchers. The counter argument here might be that the researcher and the participant are both in a normative attitude and environment; certain norms and meanings are intrinsically accepted by them. However, Hollway and Jefferson (2008) concluded that the risk in the question-and-answer method of interviewing is that it has got a tendency to suppress

interviewees' stories. If one is listening to another person expecting her to be in a similar frame of mind, the risk might be that one does not 'hear' what the other is saying.

Hollway and Jefferson (2008) emphasised that the focus of their method is the people who tell stories about their lives, and the biographies themselves are a means to understand the interviewees better. Referring to psychoanalytic theory they concluded that events which are provoking too much anxiety, will be either forgotten or recalled in a modified and distorted, usually more 'acceptable' fashion. These researchers have chosen to call their research subjects 'defended' because people may not be able to remember and talk about some of their life events due to too much anxiety. I have understood that by not being able to remember, the research subjects are 'defending' themselves against difficult painful memories. In this kind of situation, the free association method will be helpful for the following reason; if people don't have to restrict themselves to a certain topic and try logically to talk about it, their 'free talking' can reveal clues to memories and themes which otherwise would be difficult to come to mind if consciously directed. I understood the authors' view to be that if people were invited to speak spontaneously as whatever came to their minds, these kinds of more 'difficult' memories and themes will be more likely to come to their consciousness. This process will often happen without the person being aware of it by herself. Some people may consciously mislead and obscure their information, but most people will probably make helpful links between their personal issues which they have brought up by themselves when using the 'Free association narrative interview technique'. In this way, most importantly, Hollway and Jefferson (2008) have clearly brought subjectivity into the discipline of sociology by drawing on some aspects of psychoanalytic method, such as the existence of the unconscious and of free association. Their stance firmly provides supporting material for my theoretical frame of reference in my research where I was to explore, using the free association technique, whether there were some underlying less obvious factors which may determine the individual woman's psychological distress from her physical illness.

3.2.6. The Human Researcher

The psychoanalytic interview technique is very much based on emotional human interactions which go beyond the verbal dimension and the researcher in her role is playing an important part. Kvale (2003) pointed out that even though this kind of interviewing is a research method, it has also got some therapeutic elements in it. This, in my view, is the case especially then when the participants are talking about difficult and distressful issues. The psychoanalytic researcher needs a capacity to tolerate the ambiguity and not only listen to what a person manifestly says, but also, what she does not say. It is of paramount importance that the researcher herself has had her own analysis or psychoanalytic psychotherapy where she has gained a capacity for personal insight, not only related to the area of the study but most significantly, to the unconscious aspects of interactions between

two human beings. She needs to be aware of the transference and countertransference issues. The interviewer needs to be sensitive to what kind of less conscious wishes and phantasies the interviewee might have in relation to her and on the other hand, what kind of feelings and reactions this might provoke in her. It is also very vital that the researcher is well aware of her own motivations, feelings, conflicts and perceptions regarding the topic (Cartwright, 2004). In this way the researcher can disentangle her own responses from those that are specific to the person in her study. Objectivity in psychoanalysis can be only reached through considering one's own subjectivity related to the area of study (Renik, 1998). Thus, the insight gained from exploring one's own motivations, perceptions and conflicts related to the research, forms an important part of the preparation required for the interview (Hunt, 1989). It is also crucial to investigate the interview process itself by monitoring one's own affects and experiences and being able to use them as a part of understanding the underlying meanings of the interviews.

Kvale (2003) also emphasised the importance of the researcher's academic and personal training over several years as a necessary condition for conducting this kind of research. I have already described earlier the nature of psychoanalytic training, but also intensive psychoanalytic psychotherapy trainings can offer the competence for this kind of research. Kvale (2003) found it essential that the researcher is an expert in psychoanalysis or psychoanalytic psychotherapy in order to make therapeutic observations and interpretations and this is also my point of view. Hence, much of the interviewer's knowhow is based on intuitive listening. Thus, the quality of human knowledge which will be produced as a result of that interaction, is depending upon the attitude and vision of the researcher. This form of research would not be possible to conduct by novice researchers who are just following a standard method and who can be fully trained in a short period of time to conduct, for example, standardised survey questionnaires. Knowledge, rules and techniques in this latter kind of research are quickly learnt and easily transferable.

In contrast, Kvale (2007) likened interviewing to a 'craftmanship' where the person of the researcher is regarded as the main instrument. So, for that reason the quality of knowledge produced in an interview situation depends on the researcher's skills, sensitivity and expert knowledge of the theme. The skilled 'craftsman' or 'craftswoman' does not focus on the methods but on the task. Kvale (2007) referred to Heidegger's analysis of craftwork where it is not the hammer the carpenter focuses on but the wood and the table to be built. So, in the similar way the interviewer, being more like a 'craftsman or -woman' and an artist rather than a methodologist, thinks less of the interviewing technique than the interviewees and the knowledge he or she is seeking for. Undoubtedly, the tool needs to be fit for its purpose and safe for the job to be performed well but the role of the tool is to help to achieve the aim, not to take the centre stage. Good interview research goes beyond knowing the formal rules and includes more than mastering the technical skills. It also includes the

researcher's personal judgement about which rules and techniques to apply and which ones not to apply. Freud regarded this personal judgement as a tact. Empathy and tact (ability to know intuitively 'how, if and when' to intervene) are enduring and central components in the psychoanalytic act of listening (Robinson, 2014). Polanyi (1966) has stated that the focal awareness of a coherent whole is always dependent on our subsidiary awareness; our different impressions and memories that have built the 'whole'. This awareness gives us clues which stand in the background when making the focal target possible. Polanyi (1966) explained that the integration of these two kinds of awareness (focal and subsidiary) occurs in any act of knowing. What we know indirectly represents an extension of our bodies and thus our body is the ultimate instrument of all our external knowledge. This form of knowing is central to the psychoanalyst's method. It has been Kvale's (2007) firm view that therapists need not always be looking for other research methods in order to do their research but stick to the craft of interviewing where they already have expertise in techniques of questioning and interpretation of meaning. Similarly, Midgley (2004) pointed out that the skills which are needed in good qualitative interviewing, overlap a great deal, though not completely, with the skills we will learn as psychoanalysts and psychoanalytic psychotherapists.

This kind of research undoubtedly raises also ethical issues. Henderson (2012) pointed out that a qualitative researcher is a human observer and the responsibility of the researcher is a critical part of the whole research process. It is crucial that the researcher is ethically committed and responsible in facilitating the voice of her participants but at the same time protecting them from unnecessary exposure. Kvale (2007) made a very important ethical point here; in the research interview it will be unethical to initiate interpretations or facilitate emotional changes in the participants as they have not asked for that. They have not come to therapy sessions but to research interviews which will continue only a limited number of times. This is a very essential aspect that separates research method from therapy. Research interviews, likewise, psychoanalytic treatment, need to respect the person's defences and not try to break them down as this may cause unnecessary disturbance for the research participant. That kind of 'forceful' interviewing will violate the individual's consent to participate and will be totally unethical.

3.3. Understanding the Human Mind and Behaviour from Psychoanalytic Viewpoint

In the following three sections I will demonstrate how psychoanalytic theory comprehends the human mind and behaviour in our normal everyday life and stressful situations. This has been also my own theoretical framework when understanding the data collected in my study.

3.3.1. The Importance of Earlier Experiences

Psychoanalytic theory is deterministic in its view that our present-day mental life and behaviour have their roots partly determined by our earlier experiences and interactions in childhood and adolescence. These experiences, some repetitive, such as living over time in a particular environment, form the individual's personality and the future patterns as to how she will manage aspects of her life in adulthood. Very early experiences and interactions between the infant and her carer, usually the mother, leads to the gradual internalisation of the mother in some form into the infant's mind. In addition to these experiences with her close family members, the child or adolescent might also experience traumatic events, such as serious illnesses or deaths in her family or events external to the family. These incidents might have had a major impact on her later life. Many of these experiences, especially earlier ones, will be repressed from our conscious mind or they will be left there unintegrated, making us unaware of them in our everyday life. However, they continue their existence in the unconscious and preconscious parts of our mind and anxieties from them can be evoked by present-day traumatic situations. Very early experiences, of the first three to four years of a child's life, don't have conscious recollections but may be expressed without words somatically in our bodies or in our powerful emotions. So, the contemporary issue, like having an early and very treatable breast cancer diagnosed, may provoke unconsciously in a woman's mind much earlier overwhelming emotions, determined by threatening, unintegrated impressions, which are disproportionate to her present situation.

Thus, the loss of breast or a part of it may evoke other losses in a woman's life history. They become alive again and are felt in the present to be attached to the current context. These could be losses from actual deaths or other kinds of losses stemming from one's own or others' illnesses, or more abstract losses. Freud (1957 [1915]) explained that mourning comes to an end when the person's ego detaches itself gradually from what it has lost. The free mental energy can be then re-invested in a new attachment and the person can move on. In the same way a woman needs to mourn the loss of her healthy breast and what it has meant to her, so that she can move on in her life. Otherwise her anger and sadness of that loss may well be directed elsewhere; sometimes negativity is turned against herself and she may become depressed.

3.3.2. The Relationship between Body and Mind

Psychoanalytic theory, in understanding the nature of human development and mental functioning, has always acknowledged the complex relationship between the body and the mind. Our 'self'-feeling, the feeling who we are, is experienced to a considerable extent in and about our bodies. Our

mind lives through our body and generally this situation occurs without the person realising it. The infant's mind and sense of her 'self' is developing with the help of another mind, initially and mainly the mother's mind. As I have shown earlier, the mother's holding her infant's body physically (by handling, bathing, feeding and dressing her) is helping the infant's different body parts and feelings about them, to psychologically come together. When the mother is keeping her infant's experience alive in her mind, by looking at her and interacting with her, the infant will gradually form and integrate a psychological 'self'-feeling state, the feeling of who she is. She will internalise these early interactions with her mother and in this way her body always bears a trace of another human being.

The body may register and express feelings about ourselves, such as being loved or hated, and having our confidence of it or lack of it. In our body-image we carry much of our life experiences, the characteristics of our whole life. Normally, our 'self'-feeling, who we are, is not separate from our body. However, our body-image is dynamically responding to and expressing how we psychologically feel about ourselves and the same happens the other way around. If there is something wrong with our body, this may well have an impact on our 'self'-feeling. Physical illness makes us more aware of our body and we may feel that our ill body becomes somewhat separate from the rest of our 'self'. When the body is ill and especially if we don't know what is going on inside it, we may easily feel in our minds that our body and we ourselves are out of control or being controlled. The body seems to have a life of its own and its language is mute. I would say that the more serious the illness, the more the body can become like a persecutor who lives its own life, threatening the person's psychological equilibrium and this situation can provoke very powerful anxieties.

3.3.3. Dealing with Anxiety

In our everyday life we all need a certain amount of 'healthy' normal anxiety to help us to push ourselves forward and manage different challenges. Nevertheless, if the anxiety becomes too powerful and overwhelming, it will destabilise the person's normal functioning and mental equilibrium. Excessive anxiety may manifest itself in a variety of psychological and physical reactions. Neurotic and psychotic anxieties are signs of more severe internal psychological conflicts or threats to a person's mind. Neurotic anxiety is based on mental/psychic conflict of which the sources may be largely unconscious, and this can have a negative effect on the individual's ability to cope in her everyday life. Nonetheless, the neurotic person's sense of external reality stays intact whereas psychotic anxieties result in changing aspects of the person's sense of reality. Psychosis is a way of solving fragile aspects of a person's weak ego when it tries to manage overwhelming anxieties or unbearable feelings by creating a different reality.

'Realistic' anxieties are based and provoked by the real external situation, for example by an illness, in this research, breast cancer. This condition can be also a trigger that provokes other anxieties from the person's earlier experiences. This situation where the present 'realistic' anxieties may raise previous anxieties, is not obvious to many people and the point of my research was to highlight this for those for whom it is not recognisable. So, even though the anxiety is initiated by real external situations, it is the unconscious meanings of these situations which are specific and unique to the person who presents them, and which may provoke very personal issues. So, the person's life history plays an important role in determining the nature of her current anxieties.

If the anxiety threatens to become too overwhelming, our mind has additional defence mechanisms which can help us to protect ourselves. These unconscious psychological mechanisms are the individual's way to reduce anxiety so that she can manage different challenges in her life. We all need defences and healthy people normally use them throughout their life; not only, when facing danger situations, but also in order to manage their feelings in everyday life. The defence mechanisms are categorised according to that how primitive they are. By 'primitive' I refer to a child's developmental stages when these earlier defence mechanisms have been age-appropriate and normally used. I will mention here some common defences. At the more mature end there is 'sublimation' where the person is channelling her difficult feelings into more productive use and 'compensation' which reinforces a person's self-esteem. 'Intellectualisation' over-emphasises thinking without feelings and in 'repression' the person has unconsciously blocked off her difficult feelings. More potentially disabling defences include 'regression' where a person retreats to an earlier stage of development and 'denial' where the painful reality is not accepted. Suicide attempts can be seen as an example of 'acting out' in order to rid oneself of unbearable feelings. It is the person's desperate way to communicate via physical action something that cannot be managed emotionally. In 'dissociation' the person often loses track of time or herself and her usual thought processes. When a person uses 'projection', she attempts to eliminate her difficult feelings and thoughts onto another person. 'Splitting' is used when good and bad qualities of the 'self' and others are kept quite separate.

We may say that the more primitive the defence mechanism, the less effectively it will work out for the person in a long-term run. However, there are situations in our life, often traumatic ones, where we may temporarily resort to using this kind of more primitive defence for our self-protection. That can happen, for example, in a situation where we are faced with the reality of having a potentially fatal illness, such as breast cancer. When a person is faced with this kind of shocking event, her ego/mind will mobilise defences, typical to that individual, in order to manage the heightened anxieties. For example, a woman might deny the reality of her breast cancer, or she might regress into a helpless, hopeless childlike state. It is important for us to realise that these anxieties are the

expression of the unconscious meaning which the contemporary problem has for the person. It is the meaning that is traumatic, not necessarily the incident itself. The process of gaining more control of one's powerful anxieties and claiming back the usual way of functioning may take some time. Typically, the person will gradually re-find her own ego strengths, and this will assist her to be able to move on in her life. This process will be helped by her internalised good 'objects' in her mind; her early experiences of 'good enough' childhood figures who helped her to manage her feelings in a distressful situation.

3.4. Method Used in my Research

3.4.1. Choosing my Method

In my student days, when studying psychology, I became used to strict positivistic thinking, the dominating approach in that time. The traditional methodology of all psychological research was quantitative, derived from natural sciences and characterised by testing hypotheses which were developed from existing theories. A systematic empirical investigation was used to observe phenomena via statistical, mathematical and computational techniques in trying to evaluate hypotheses. The quantitative method quantifies and reduces its data into a numerical form, such as statistics or percentages. Typically, the data is often collected from a bigger population, by using polls, questionnaires and surveys for example. The results are achieved by describing the variables, looking at the correlations between them and determining their cause-and-effect interactions. Thus, in the quantitative research method, numerical data is used to obtain information about the world and its people (Midgley, 2004). It is presumed that the social world exists objectively and externally, and knowledge is valid only if it is based on observations of external reality. There are only universal and general laws of human behaviour and the epistemological approach, the study of knowledge, is focused on reason, truth, validity and facts (Flowers, 2009).

However, since first qualifying as a psychoanalytic psychotherapist and then as a psychoanalyst, this very 'concrete' kind of 'quantitative' approach where the 'human experience' was missing, gradually became alien to me. The area of interest that I wanted to explore, was breast cancer and how women psychologically managed their illness. I then needed to find a method that best suited to my research question and one that was close to my own understanding of the psychology of human beings. This understanding, based on psychoanalytic theory, I had developed during my theoretical training and my clinical work with my patients. I was aware of the ontological debates; how we, as individuals, see the world with objective and subjective realities, and whether our view which we have created in our minds, will then affect also our research work. As Flowers (2009) has

stated, we all have several deeply fixed ontological assumptions which will influence our view on what is 'real'. I totally agree with this approach and regard my subjective reality as my 'internal reality', my 'external reality' being the objective one. Nevertheless, it is my understanding that, because of different kinds of 'internal realities' due to people's personal experiences and historical backgrounds, we don't always see and experience 'external realities' in the same way.

When I started to develop my research method, I read papers and books about the research methods more traditionally used in social sciences, such as grounded theory and phenomenological analysis (Anderson, 2006; Charmaz, 2006; Dawson, 2002; Glaser, 1965; Gibson & Hartman, 2014; Suddaby, 2006; Wertz, 2011). I also watched Dr Gibb's (University of Huddersfield) talks on grounded theory and read some papers (2005 & 2008) by Prof Freeman (Dundee University) who has used grounded theory with the psychoanalytic approach when investigating dental practices with children. I also had discussions on methodological issues with my supervisors. Consequently, I was positively surprised to see some similarities between both grounded theory and phenomenological analysis and my own psychoanalytic understanding. Regarding grounded theory, I especially found Anderson's (2006) notion helpful when she argued against the criticism that the clinician's mindset will frame the findings in psychoanalytic research (Grunbaum, 1984). She pointed out (referring to Kuhn, 1970) that it was not possible to approach the study with an empty mindset and that the theory and practice in psychoanalysis is not significantly different from other scientific fields. Anderson (2006) concluded that it is totally acceptable that the psychoanalytic research-clinician has a mind that is trained to see things in a certain way in his or her research work. Even though Gibson and Hartman (2014) underlined the need for openness and creativity, they clearly stated that no one can totally free themselves from their preconceptions.

All this reassured me that as a researcher I could conduct my study using my own theories available but at the same time being aware of my preconceptions. After all, these were the theories I had studied and used in clinical practise for many years and they were, and continue to be, part of my own professional identity. I could not deny my own pre-conceptions, but I needed to recognise them and not allow them to restrict my observations. I understood Flowers' (2009) argument that if the researcher holds certain ontological positions or assumptions, these may influence the epistemological choices, the ways how she gets knowledge and make conclusions. However, an important point here again is that the researcher needs to be aware of that. In social research we cannot achieve 'true objectivity'. We see our external world from a 'subjective' point of view. If different views exist regarding what the 'objective' reality is, then another question is how that reality is measured and what constitutes knowledge of that reality (Flowers, 2009). Glaser's (1965) advice was to do grounded theory research with an 'empty mind' and without any hypothesis. I wondered whether he actually meant, by an 'empty mind', an 'open mind'. A mind that is not firmly fixed in

advance to a certain idea but will be open to look at different possibilities in a creative way. At one end, the interplay between openness and creativity, a researcher's free-floating attention and at the other end, the theoretical mindset of a researcher, made me think about my own work as a psychoanalyst and psychotherapist. I need to approach my patients with an open mind at the beginning of every session, but I also need, as my tools, my theoretical background and my previous knowledge of my patient, when making sense what she is communicating to me. I decided that this kind of 'double' mindset would be most helpful in my study.

I found some other interesting similarities when I was familiarising myself with grounded theory. In grounded theory the researcher's interest might be first in more subjective material but the primary interest is not only 'the stories themselves' but the social context in which they are told (Suddaby, 2006). Perhaps in somewhat same way, in my own work, my interest is not only in my patients' stories, but my underlying goal is to try to understand from a psychoanalytic viewpoint, how these stories reflect my patients' internal psychic world. In grounded theory there is a movement from relatively superficial observations to more abstract theoretical concepts in which process the collected data and its analysis is constantly interacting. In this picture I found some notable links with my own work because listening to my patient's material and interpreting it to her, is like 'a constant interplay between collecting data and interpreting it'. Furthermore, Suddaby (2006) pointed out that grounded theory should not be used to test hypotheses about reality, but, rather, to make statements about 'how actors interpret reality'. I found this thought again very fascinating as in my own work, I am interested how my patients interpret their external reality and then make it into their own internal reality. In my research work, I was curious to know how the external physical reality, having a breast cancer, was interpreted by the patient and then experienced in her own internal reality. Furthermore, Suddaby (2006) emphasised how important it is that the researcher needs to be sensitive in order to interpret the data that might not be apparent from a mere superficial examination. He says that many grounded theory researchers describe this kind of interpretation occurring subconsciously, as a result of their constant 'immersion' in the data. This reminded me of the countertransference phenomenon in my own work; by this I mean aspects of the thoughts and feelings that have been evoked in me by the patient. I need first to disentangle them from my own personal meanings which have been aroused by my patient's communications.

I compared grounded theory with phenomenological analysis which I also found interesting. I realised that there are many common features between these methods, such as line by line-analysis, the use of empirical data for modifying concepts and the importance for the researcher to be critically reflexive, sensitive and to use her creative personal thinking. Both are studying concrete human experiences. However, my understanding was that the phenomenological analysis remains descriptive and does not construct a theoretical model that generates hypotheses whereas grounded

theory constructs a theoretical model and produces hypotheses (Werz, 2014). I also understood that the aim of grounded theory is to construct meaning and build a theory based on it but for the phenomenological description the experience as such is already meaningfully organised and intelligible without any other theory, but only in need of descriptive conceptualisation. Description limits itself to explaining 'holistic' psychological structures when 'being in the world'. Wertz (2014) continued that phenomenological research aims at 'general knowledge'. I understood that 'general knowledge' describes a phenomenon, the essence of which has been collected from different examples, all sharing between themselves some common general features. And in one sense, this is a theory itself. Descriptive phenomenology aims to explore and describe the lived experiences of individuals from which we may be able to identify differences and categorise these as a basis for further research.

After considering other methodological options and finding some interesting similarities in them with my own theoretical understandings, I decided to stick to psychoanalytic theory as the best approach for me in helping me to answer my research question 'How women psychologically experience their breast cancer diagnosis and its subsequent treatments'. I was keen to explore whether there were any underlying less obvious factors linked with the level of psychological distress, I thought, I was going to find. For this purpose, I decided that the psychoanalytic method was going to be the only possible option for me.

3.4.2. My Method

My methodology for this study was based on psychoanalytic theory. In the application of this approach I used as my main method of data collection a semi-structured psychoanalytic interview, as earlier described in this methodology section by Cartwright (2004) and Kvale (2003). I also prepared a short questionnaire for the patients to fill in at the beginning of their interviewing process. The function of this questionnaire will be described at the end of this methodology section. My study was going to be longitudinal with four interviews for every patient so that I could follow each participant through different stages of their treatment. My study demonstrated a strong clinical link with the hospital's Breast Unit as the idea for the research arose from the staff members' experience that the level of psychological distress amongst their patients often bore little or no relationship to the stage or prognosis of their physical illness. The practicalities as to how to conduct the study were discussed with the aid of the surgeons and breast care nurses. All the staff members were very helpful in supporting my research idea and in enabling me access to the Breast Unit. Before starting the actual recruitment process, I went to talk about my study in the Multi-Disciplinary Team meeting and in the breast care nurses' meeting. During the data collection I often participated in the MDT

meetings which was a good way for me to get to know staff members and their work, and for them to get to know me which was helpful in the recruitment process.

3.4.2.1. Recruiting Participants

My study offered an opportunity for patients who wanted to talk about their experiences with breast cancer. Ten women with newly diagnosed primary breast cancer, with no history of previous breast cancer or any other cancers, were invited to volunteer to participate in this study. The pre-condition was that the women were all going through a breast operation, either lumpectomy (the removal of a part of the breast) or mastectomy (the removal of the whole breast), followed by chemo- and/or radiotherapy. This group was going to include women with asymptomatic breast cancers, detected by routine screening methods, as well as symptomatic breast cancers, discovered by the patients themselves. The other pre-conditions were that the patients had already heard about their diagnoses and were waiting for the operation. Owing to the design of my study, it was important that the first interview happened before the operation when the patient was not yet aware of the more detailed physical findings and extent of her illness. This arrangement allowed me to 'follow' the patient right from the beginning of her breast cancer treatment. There was no upper age limit for the participants, but the lower age limit was twenty years which I regarded, based on my knowledge and experience of developmental psychology, as the age where a young woman has normally, at least to some considerable extent, built up her own identity. Moreover, the breast cancer is rare in the younger age group (under twenty years).

Women who had clearly identifiable and more severe mental health problems or addictions, were excluded from this study as otherwise it would have been difficult to differentiate, how much their current distress was linked with their present physical illness and how much with their other previous psychological problems. Because of the in-depth and very personal nature of the interviews, it was, unfortunately, very difficult to include in this study women who could not express themselves adequately in English. The participant's language skills did not have to be perfect by any means, but her English needed to be comprehensible enough. Having an interpreter present in a room might have totally changed the personal nature and trust of the interviews. The absence of mutual language would have led to complexities when trying to analyse and interpret something that had been already interpreted by a third party. However, these kinds of restrictions in communication could be a useful subject for further research with different cultural and ethnic groups. I had prepared a 'Staff Information Sheet', in order to help staff members to recruit suitable patients for the study. Exclusion from the study were under the age of twenty years, known severe mental health problems and limited communication skills in English (Appendix no 2: Staff Information Sheet).

It was the breast care nurses, who played the main role in the recruitment. The nursing staff were very experienced and often had more regular and personal contact with the patients than the other professionals. I had hoped to be more in charge of choosing the participants but practically it was not possible. Due to the nurses' work commitments, there was not really a suitable meeting that I could have attended in the Breast Unit. The interviews were offered to those patients who, the nurses felt, might have benefitted from talking about their experiences. Because of the technical limitations, I had no way of knowing if someone who did not openly express her interest in participating, might have actually been interested to take part. If the patient showed interest in participating after the nurses' offer, she was given the 'Patient Information Sheet' about the study with my contact details (Appendix no 3: Patient Information Sheet). In the information sheet I first introduced myself and explained the purpose of my study. I highlighted that, before the patient was going to decide anything, it was important for her to understand why this kind of study was being done and what it might involve for her. I asked the patient to take time to read the information carefully and to discuss it with her family members or friends, if she wished. I also encouraged the patient to contact me directly by phone or email if there was anything in the study that was not clear for her and if she wanted to have further information. I advised the patient to allow herself time to decide whether she wished to participate. However, it was important, due to the nature of the study, that she made up her mind well before her breast operation. After having made her decision to participate, the patient was asked to contact me directly in order to arrange a suitable time for the first meeting. It was important here that it was the patient herself who contacted me so that the decision was made solely by her and she was not feeling being pressurised to participate by anybody. This recruitment method functioned well as most participants made direct contact with me and only a few patients asked, via the nurse, me to contact them.

GPs were informed of the patients' participation in the study by a standard 'Letter to GP' (Appendix no 4: Letter to GP). Before the participant began her first interview, she was asked to sign the 'Consent Form' (Appendix no 5: Consent Form). Here I followed my research protocol and ethical principles as agreed with the ethics committee. At the end of the first interview the participant was given a short 'Questionnaire' which she filled in whilst at home and brought or posted it to me in a prepaid envelope (Appendix no 6: Questionnaire).

3.4.2.2. Interviews

I used the semi-structured interview as my main method for collecting data. Each interview was going to last up to 60 minutes depending on how much the patient wished to talk. My professional experience had shown that this length of time was often needed for a therapeutic interview, to give enough space for more confidential and difficult matters to be discussed. The length of the interview

sessions abled me not only to focus on certain questions linked with breast cancer, but also to keep the interviews open-ended and indirect. Thus, the patient was encouraged to speak freely about her own experiences of her breast cancer and all the thoughts and feelings provoked by her illness. I had no rigid rules as to how the interview should progress. The idea was to provide enough space to make it a creative interaction between two individuals. It should be stressed that my plan was definitely not to offer any psychotherapy or psychoanalysis for these patients, but only to understand their state of mind from a psychoanalytic point of view. However, I anticipated that the interviews might well be helpful and therapeutic for the patients when they were trying to come to terms with their illness. The interviews were open in a sense that the participants were free to talk about issues they found important, but they did not need to bring up anything too distressing.

The interviews were audio-recorded with the patient's consent. I was first struggling in my own mind with the idea of having to record the interviews as it was an alien idea in my own everyday work with patients. However, I understood that it was an important feature of a research method. My main concern was that recording the talk of the patients who were already in a very vulnerable situation with their illness, might have stiffened the atmosphere and disrupted the creative process. Nevertheless, in hindsight, this worry proved not to be valid. The recorded interviews were then professionally transcribed and anonymised. I used digital software NVivo for organising and categorising the material from the interviews for further analysis. To start with, for familiarising myself with Nvivo I found the on-line introductory lectures by the Lane Medical Library of La Trobe University, US very helpful. I then had some further practice and essential technical guidance how to organise my data when using this 'electronic filing cabinet'. For reasons of confidentiality all the data was kept in a safe place. It was held in a locked cabinet in my consulting room at home and in the secretaries' room at the hospital. This was a locked room where the Breast Unit patients' files were kept and in no circumstances was the room accessible for outsiders. The data was going to be later deleted for confidentiality upon completion of the research.

Each patient was offered four individual interviews by me at different stages of the treatment. By offering these successive interviews for each patient, I was able to follow every patient through her treatment process. The number of interviews was decided after discussions with staff members and based on my own understanding of the longitudinal nature of this treatment. This arrangement allowed me to look at the patient's whole treatment 'journey' instead of just concentrating on one particular stage in her illness. Murray et al. (2009) have highlighted many advantages of longitudinal qualitative research. They stated, interestingly, that this method is rarely used even though interviewing patients over the course of their illness can give a much better picture of the patients' experiences. They suggested that several interviews increase contact between the participant and researcher allowing a relationship to develop. This in turn will facilitate discussion of more sensitive

and personal issues. I want to emphasise here that I regard my method as a novel and innovative approach, compared with the previous 'snapshot' studies which I had come across when doing my literature research. Instead of focusing on a certain stage of the illness or its treatment, I was now exploring a woman's overall experience of her illness and how her other life experiences may have affected on the level of her present psychological distress. Moreover, this sequence made it possible for me to explore less obvious underlying reasons for any levels of distress as the interviews were open for free association due to sufficient time being available at each meeting. The interviews were conducted in the same small private interview room in the Breast Unit without any interruptions from outside. Depending on the individual treatment schedules, which could not be determined in advance, I anticipated that the whole interview process with one patient was going to last a maximum of nine months. I had planned, before the actual interviews, an initial meeting with every patient where I was going to explain the study and answer to any questions she might have had. Nevertheless, the initial meetings turned out to be totally unnecessary because all the patients were 'bursting' to talk about their experiences straight away.

I had arranged the first interview for the patient very soon after she had been given her diagnosis but had not yet had her surgical procedure. At the beginning of that first interview I went through the patient information sheet with her after which she signed the consent form. At the end of the first interview I gave the patient a questionnaire which she filled in whilst at home and later returned to me. The second interview followed after the patient had had her breast operation and she had heard the findings from it. The third interview took place during the course of chemo- and/or radiotherapy and the fourth interview was intended to take place after all treatments had been completed. However, the treatment of two patients was lengthened for medical reasons and I could not, because of the pressures with my own research timetable, follow them right till the end. Anyway, the fourth interview took place towards the end of their treatments. My plan was to see everybody in the Breast Unit, but again, I needed to be flexible. A couple of patients could not always travel to the Breast Unit for various, mostly practical and medical reasons, and in this kind of situation I decided to go to see them at their home, usually quite far away, and this turned out to be a good arrangement. I did not find any major difference when interviewing the patients at home. They all welcomed me and in hindsight perhaps the most important issue here was that I was by now a familiar person to them. Two of these three patients I had already interviewed at the hospital and with the third one I had had a few phone calls. These patients appreciated that I was prepared to accommodate them in this way in their stressful situations. Being adaptable to these patients highlighted the human element and my flexibility in this study. And from my point of view, it was crucial that this flexible arrangement made it possible for their interview schedules to continue and be completed.

It was important for me that immediately after interviewing, I had time to document my impressions and other nonverbal material that might not be revealed in the recordings as this helped me to form a whole picture of the patient. I was clear what issues I was going to ask about in the interviews but at the same time I did not rigidly plan how I was going to raise my questions. I allowed the patient to take the lead. I very much used and needed my long-term clinical experience to understand where my patient was psychologically at any particular moment and what kind of things she could manage to talk about. I intended to cover certain topics but the order of them varied from patient to patient. Not everybody talked about the same issues. I used my theoretical knowledge to understand the material in my own mind, but I restricted myself in each case from making any interpretations to the patient in the interviews. The reason for not interpreting was that these patients had come for four research interviews, not for therapy sessions.

I had been clear, right from the beginning, that the interviews were not going to be therapy sessions as these patients were not asking for it and it was also a strict pre-condition for the study from the ethics committee. It would have been completely unethical to start interpreting or encouraging emotional changes in the patients who had come only to tell me how they were psychologically coping with their breast cancer diagnosis and its treatments. To interpret things in this kind of situation might have stirred up issues in the patient's life that may not have been manageable in the course of four interviews. However, I anticipated that the interviews inevitably included therapeutic elements when the patients were given the opportunity to talk about the distressing issues in their minds. The value of a 'therapeutic role' in interviewing when researching sensitive and private aspects in people's lives had been also recognised by Birch and Miller (2000). I was listening to the patients' material with a 'third ear', a psychoanalytic term first used by Reik (1948), a well-known psychoanalyst who trained as one of the Freud's first students in Vienna. 'Listening with a third ear' is a theory of psychoanalytic listening where psychoanalysts intuitively use their own unconscious minds to tune into their patients' unconscious wishes and phantasies. In the interviews I was trying to understand the underlying factors in the patients' worries and interpreting things in my own mind, not verbalising them to the patients. That was different from a psychoanalytic therapy session where I would have actively taken these issues up. That kind of intervention would have needed more regular sessions with the patients for a different kind of therapeutic relationship to develop (as I have described earlier in this methodology section). It was extremely important for me to keep these two things, research and therapy, separated in my own mind.

In the following I will describe what kind of questions I was intending to ask the patients. The questions were particularly relevant to the different stages at which the interviews took place. However, it did not mean that all these questions were covered with every patient as she could free associate and share with me the issues, she found most important. The first interview happened

soon after the patient had received her diagnosis of breast cancer. The potential core topics, in no particular order, were: How was your diagnosis given to you? Do you know what is happening? How do you feel now? Are you frightened? Anxious? How do you manage all this? How do you feel about your future? What kind of support do you have? Have you had any serious illnesses before? How did you manage then? The second interview was after the operation and after the patient having heard the findings from it. The core topics were: How did you experience your hospitalisation? Your operation? The results of it? The loss of your breast or a part of it? What kind of other losses have you had in the past? How do you see your body now? How do you feel about your future? Are you frightened? Do you know what is happening? Have you got any support? The third interview was in the course of chemo- and/or radiotherapy. The core topics were: How do the treatments make you feel? How do they affect your body? Have you got support? The fourth interview happened, if possible, a few weeks' after all the treatments had been completed. The core topics were: How do you feel now? How is your life going? How do you manage? What do you think about your experience now? What do you think about your future? Have you got support?

I used such open questions to elicit as much information as possible and to facilitate free association responses which allowed greater access to the patients' underlying unconscious material. In this stage, I was careful not yet to formulate the material in psychoanalytic terms. After having had all the patients' responses, I went through the collected material. I used my 'open mind' as a psychoanalyst when looking for emerging themes and, in somewhat similar ways, following grounded theory principles. And only after this point, I started to approach the emerging themes from psychoanalytic viewpoint. However, in this stage I did not have any definite plan how I was going to organise all the rich material. In the following 'Results' and 'Discussion of Results' sections I will show in more detail, how different themes, such as 'Losses' for example, could be understood in psychoanalytic terms.

3.4.2.3. Questionnaire

At the end of the first interview session the participant was given a short questionnaire to fill in whilst at home. The main purpose of the questionnaire was to collect more general information about the patient's life situation and background. The questionnaire was applicable to my study. It helped me to collect mainly demographic information which may have been difficult to gather in the interview situation, where I wanted more emotionally significant aspects to take the foreground. Nevertheless, this information from the questionnaire was going to help me to get a wider picture of the patient's life and it was an additional aid to make meaningful the data from a psychoanalytic perspective. While many of the questions collected factual information, some were slightly more open-ended,

encouraging the patient to answer in her own words about her family history, personal background, education and employment, and domestic life, relationships and health.

I had permission to use a Psychotherapy Questionnaire, originally formulated for patients with psychological problems who attended to the Regional Department of Psychotherapy. I chose this questionnaire as I had used it before, and it fitted in well with the purposes of my study. However, I had shortened and modified this non-validated questionnaire for the needs of breast cancer patients as the original one was focusing on mental health problems.

3.4.2.4. Assessing the Trustworthiness of the Data

Because my study was not going to use any quantitative methods, I could not offer any numerical data, such as statistics or percentages. I have previously pointed out how a researcher in a qualitative study is using her empathy and tact; her intuitive listening and implicit knowledge which skills are not transferrable as such from one researcher to another. I was aware of my own subjectivity as we cannot be totally 'empty minded' but, most importantly, I had to be aware of that and not allow my own frame of mind to interfere my findings. Neutrality and objectivity are important parts of the research process, but they also belong to psychoanalytic and psychotherapy trainings. I was going to use my 'analytic listening' technique which meant empathically listening to the patient's communications but at the same time trying to understand them by using my meta-psychological knowledge. Beyond the setting I offered, I did not influence the patients to bring to me any particular issues and I hardly needed the potential questions I had prepared as most patients were 'bursting' to talk. I described accurately their distress and a colleague who read all the transcriptions ended up independently with similar kinds of conclusions.

Somewhat in the same way as grounded theory formation, my findings started to become consistent and repetitive themes were emerging. My research method can be replicated with different patient groups. The breast is a very sensitive part of a woman's body, and I speculate that breast cancer will provoke powerful issues in all age groups, but probably younger women's concerns may be different from older women's. My general idea that excessive distress is not only linked with the severity of physical illness but may have links with some less obvious factors in a person's life, could be investigated with other cancer patients and with patients suffering from other physical illnesses.

3.5. Organising the Material

3.5.1. The Questionnaires

All patients had filled in a short 'Questionnaire about your life' at the beginning of the interview process. The idea of this questionnaire was mainly to gather demographic details that might have been experienced as disruptive by the patients if these had been asked during the actual interview situation. The data from the questionnaires was not analysed and its main purpose was to describe the patients' background. The open questions turned out to be not essential, as the same issues came up in the interviews in a much livelier way.

3.5.2. The Interviews

The ten patients, who were interviewed four times each, therefore gave me material from forty interviews. The contents of the interviews were emotionally rich and powerful, giving me a lively picture of how the patients, in their own different ways, were psychologically coping with their breast cancer diagnosis and all its subsequent treatments. I then needed to find an appropriate method how to manage and organise all this material.

3.5.2.1. Patients Reactions to the Illness Process and Short Case Summaries

My main approach was to explore the whole illness process and the various thoughts and feelings it raised in the patients' minds. It included the patients' reactions to different phases in their treatments, how they managed these and what kind of other less obvious underlying issues these contemporary concerns provoked in their minds. In this approach I treated the patients as a group. In addition to this method where I was focussing on the actual illness and how it was experienced by different patients, I also wrote short case summaries about individual patients. However, I have kept these narratives brief and more on a surface level. These summaries were different from those case studies I discussed earlier because these research patients were not in the treatment and the summaries did not include detailed sessional material or background information. Revealing too much individual patients' life history would have caused problems of confidentiality in this type of research. By confidentiality I mean that the patients might recognise themselves or be recognised by the public. Keeping in my mind the very private and personal nature of the research, this kind of more detailed account of the patients' life situation and background just would not have been feasible. Nevertheless, I felt that some information about the individual patients was important to

present here in the connection of other material from them as a group, because in this way the individuals became more alive for a reader, but their privacy was not compromised.

My first step was to read through all four interviews from each patient (a total of 40 interviews). That gave me a general overview of the kinds of issues in the patients' minds at different stages of their individual illness process. I found, as I had expected, that the first two interviews contained major anxieties related to having recently received the diagnosis and having to go through the surgical procedures. But interestingly, these issues were often still present in the later interviews as well. One might have thought that certain topics had been resolved and talked through, but they were not in fact left behind but were often repeatedly preoccupying the patients' minds later on.

This vast amount of material was collected using the free association technique which gave the patients a central and leading position in the interview situation. They were encouraged to talk about whatever they wished to express, not only about their illness, even though that was the main context for the interviews. This kind of technique, where the patients were free to tell me all kinds of things from their life, also brought up to the surface, material which was not too obviously directly linked with their breast cancer. However, my thinking is that talking about these other topics was important for the patients, in that it gave them confidence that they could also open up and talk about more vulnerable themes in a substantial way. The fact that the patients had the continuity of my being the only interviewer in each of the four successive interviews was an innovative approach. I want to stress that this kind of consistency helped the patients to build up an emotional trust in me and feel 'safe' in the interview setting. The physical setting played also an important role as the interviews were carried out in the same private and confidential location at the hospital, without any external disturbances. In this way the patients allowed themselves to expose aspects of themselves and talk more openly about their personal and painful issues. The continuity and safe setting are also very important features in psychoanalysis and psychoanalytic psychotherapy.

All the recorded interviews were professionally transcribed. As my research was qualitative and based on unstructured interviews around the topic of breast cancer, I needed a suitable basic way how to store and organise this extensive material. In this process I used NVivo software, for storing, managing and exploring the material. As the NVivo technique does not favour any specific methodology, it suited for my purposes very well. It allowed me to start developing my own ideas by using first more general chunks of information and then gradually getting into more detailed content which I then understood from a psychoanalytic viewpoint. I also wrote memos of each individual patient describing their main issues. However, many of the patients presented themselves in a very animated way and it was in fact very easy for me to keep them alive in my mind without any memos.

3.5.2.2. Categories of Thematic Contents Based on the Interviews

Having read through all the interviews and gained a general feel about the material, I then progressed to my first approach which was going to be the whole illness process and how different women psychologically reacted to it. I formed five main categories in NVivo-software ('parent nodes' in Nvivo-language). These main categories were solely based on the thematic contents of the interviews. The categories were not my own inventions and I did not use psychoanalytic theory in constructing them. The categories were strictly based on the areas which I found that most of the patients had been talking about, some more and some less. So, in this way they were the patients themselves who helped me to form these categories.

These five themes I named as 'Being Diagnosed', 'Having Treatment', 'Getting Support', 'Losses Endured' and 'Long-term Impact of Breast Cancer on Patients' Life'. After forming these main categories in NVivo I then transferred all the relevant material into their appropriate main thematic categories. After that I went through again all the material in the main categories looking out for sub-themes that the patients had brought. Based on that exploration, I then formed sub-categories ('child nodes' in NVivo-language) which were subgroups to the main categories as in the following ways:

- The 'Being Diagnosed' main category included two subcategories which were the patients' 'Psychological Reactions to the Diagnosis' and their 'Psychological Reactions to the News about the Cell Pathologies'.
- The 'Having Treatment' main category contained subcategories of patients' reactions to different treatment procedures which were 'Surgery', 'Chemotherapy', 'Radiotherapy' and 'Endocrine Therapy'.
- The third main category 'Getting Support' included subcategories of various potential sources from which the patients could have received support. These were the support from the patients' 'Partners', their 'Family and Friends', the 'Staff Members at the Hospital' and the 'Work Colleagues'. The last sub-category in this group I named as 'Emotional Loneliness' which reflected the lack of support in the patients' minds.
- The fourth main category 'Losses Endured' included subcategories of 'Patients' Own Illnesses', the 'Other People's Illnesses', the 'Previous Deaths' and the patients' 'Loss of Identities' and 'Loss of Relationships'.

- The fifth main category 'Long-term Impact of Breast Cancer on Patients' Life' included two sub-categories; 'Impact on Body' and 'Impact on Mind'.

My final step in this process was to extract all the interview material that related to these sub-categories and allocate it appropriately. Following that I started to explore the common and different ways that the patients responded to these key issues.

To demonstrate how I organised the material into the main categories and then into the subcategories, I will give here two examples:

The first example:

'Patient G' who, I concluded, did get plenty of practical help from her husband, was still left feeling emotionally lonely. In the course of her four interviews, she told me the following things all of which I recorded into the main category 'Getting Support'.

1. Main category 'Getting Support':

But my husband, he was heartbroken. Well, he was, he took it so hard himself. So, I just don't talk about it to him because I know he gets upset. - My husband has been marvellous. He won't let me do anything, making the bed, hoovering up. I'm not an invalid but.... – No, we don't talk about it at all (1st interview).

He has been very good. He has taken over the housework and things like that (2nd interview).

Oh, he's very helpful. He doesn't let me do things, you know (3rd interview).

He couldn't even say the word 'cancer'. He would always say the 'tumour' or the 'thing' (4th interview).

All the above material I organised further into two subcategories:

1.a. 'Partners':

My husband has been marvellous. He won't let me do anything, making the bed, hoovering up. I'm not an invalid but.... – He has been very good. He has taken over the housework and things like that. – Oh, he's very helpful. He doesn't let me do things, you know.

1.b. 'Emotional loneliness':

But my husband, he was heartbroken. Well, he was, he took it so hard himself. So, I just don't talk about it to him because I know he gets upset. – No, we don't talk about it at all. – He couldn't even say the word 'cancer'. He would always say the 'tumour' or the 'thing'.

The second example:

'Patient L' was extremely worried about losing her breast. The loss meant to her that she would also lose her feminine identity. It turned out that 'L's fear of losing her breast was actually linked with other very difficult losses.

2. Main category 'Losses Endured':

When I was younger, I always had large breasts . – But people, I guess, liked my breasts. It was a part of me that people actually liked. – So, just to throw out, 'Oh, we will just go and (operate)... I was like, 'I can't deal with this'. – Yes, because you are losing your hair, you are losing your breast, you are losing everything that makes you a woman.... – I lost a little boy in 2011. That was a stillbirth. I had a breakdown after losing him. 'I can't do this anymore' (1st interview).

So, we had a meeting and I said to them 'look, I have PTSD and I had a child who was born not alive because of doctors' mistakes'. – So, you're jumping all over my trigger points (here 'L' is referring to her mistrust in medical profession and their 'mistakes') when you're just stabbing away at me (with needles) and you're not communicating anything (3rd interview).

What I wanted to do in 2017, was to renew my wedding vows. And obviously then, the breast cancer op, and now we've got no hair. Everything's been delayed. – Because I look like lesbian. – We had a little boy, but he was the one who died (4th interview).

The above material I organised further into two subcategories:

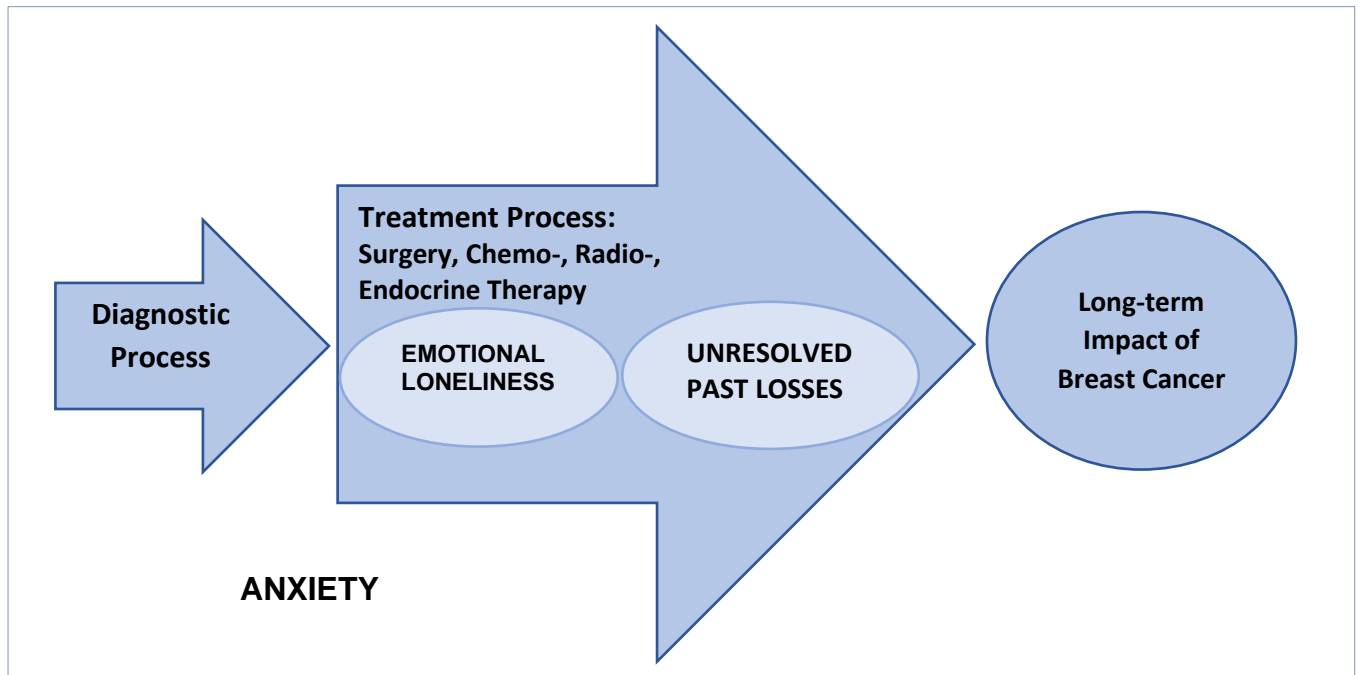
2.a. 'Loss of Identities':

When I was younger, I always had large breasts . – But people, I guess, liked my breasts. It was a part of me that people actually liked. – So, just to throw out, 'Oh, we will just go and (operate)... I was like, 'I can't deal with this'. – Yes, because you are losing your hair, you are losing your breast, you are losing everything that makes you a woman.... - What I wanted to do in 2017, was to renew my wedding vows. And obviously then, the breast cancer op, and now we've got no hair. Everything's been delayed. – Because I look like lesbian.

2.b. 'Previous Deaths':

I lost a little boy in 2011. That was a stillbirth. I had a breakdown after losing him. 'I can't do this anymore'. - So, we had a meeting and I said to them 'look, I have PTSD and I had a child who was born not alive because of doctors' mistakes'. – 'So, you're jumping all over my trigger points when you're just stabbing away at me (with needles) and you're not communicating anything'. - We had a little boy, but he was the one who died.

The diagram below shows the major sources of anxiety at different stages of the process of the illness.



4. RESULTS

4.1. Overview

I will explain now, how I understand the material that I have collected from the interviews and questionnaires. As Cartwright (2004) has indicated, the use of psychoanalytic ideas has been for some decades widely applied to many areas of everyday life outside the clinical setting and consulting room. Psychoanalytic theory can be also useful, as I have shown in the literature review, in understanding the individual dynamics and emotions of persons who are experiencing medical illnesses. As Solms (1995) has pointed out, a physical illness is experienced as threatening to disintegrate our bodily ego. This threat can create distress, associated with earlier narcissistic traumas, often with losses.

Because the diagnosis of breast cancer and its treatments may well be experienced as a traumatic event, not only for the woman herself but also for her family, it is important not only to understand the anxieties linked directly with the current illness, but also other anxieties provoked by the experience of the illness. Obviously, not every woman will be traumatised by her breast cancer experience and some will take it in their stride. However, my research has indicated that breast cancer affected these women's capacity to cope and sometimes the distress threatened to become overwhelming and exceed the person's ability to handle her situation. How the individual woman faces her breast cancer and its treatments may well vary according to her past experiences and background. The psychoanalytic approach is one that particularly focusses on individual subjective meanings.

In my research, all the patients I investigated, had one thing in common, the fact, that they had breast cancer. All ten patients informed me that they understood the 'Patient Information Sheet' and 'Consent form' and no one had any further questions about them. As discussed in the methodology section, the initial meetings I had planned before the actual interview process, were not needed as the patients were straight away anxious to talk about their experiences. Even though my plan was to try to fit the interviews into the same day when the patient had another appointment at the hospital, this arrangement was not practically possible because it turned out to be that there were only certain times when I could use the interview room in the Breast Unit. However, this situation did not seem to be a problem for the patients as they were willing to accommodate themselves to these practical limitations. I offered to fund the travel expenses but only one patient (and on only one occasion) accepted my offer to pay expenses and that was her parking fee. I thought that this may have been a sign that the patients found the interviews beneficial and helpful for themselves and did not need

financial compensation. I also needed to be flexible and adjust myself to the patients' situations. One of the patients refused to come to the hospital for the interviews because she had felt not being understood by a staff member. However, she was happy for me to come and interview her at her home where she felt safe. With two other patients I also visited a few times at their homes as they were unable to come to hospital for medical reasons. I did not experience that this affected the interviews in any way. Altogether only seven out of forty interviews happened at the patients' home (Appendix no 7: Setting of Interviews). The whole process of recruiting and interviewing all ten patients took seventeen months from April 2016 till August 2017; a typical length of time needed for one patient to go through the four interviews, was from six to seven months (Appendix no 8: Interview Dates) and the majority of the interviews lasted 40 to 60 minutes (Appendix no 9: Length of Interviews).

It was interesting to note that they were mainly the older women who wanted to participate in this research even though the interviews were offered to anyone over 20 years old who wished to talk about her experiences with this illness. Probably there were more unconscious reasons for the older women to share their experiences with me as the loss of breast or parts of it clearly brought alive also many other losses in their lives. The older women were also already much more aware of their mortality and probably more philosophical about their lives. The two younger patients who were 23 and 43 years old, dropped out after the first interview. I questioned whether the younger women just found it too painful to face their present situation. Breast cancer amongst younger women is often more aggressive which may have caused unthinkable anxieties and fears about their future. Related to these disturbing anxieties is the likelihood that if the younger patients needed chemotherapy, they probably would have to face a premature menopause with a possible loss of their fertility which would have meant an additional threat to their feminine identity.

I have divided the results into three parts. In the first section I will give a general overview of the patients. This information I have collected from the questionnaires. In the second section I will be looking at the various thoughts, feelings and preoccupations amongst the patients as a group during the different stages of their illness process. This material is solely based on the interviews. In the third section I will describe, in short case summaries, the material which I had exclusively collected from the interviews, to show how the individual patients were coping with their situations.

4.2. Patients' Background Information Taken from the Questionnaires

In what follows, I will first give some demographic information about the patients' background (presented here as a table) which I collected from the questionnaires. This indicated that most of the patients (7/10) were in the age range between 60 to 70 years, the youngest one being 49 and the oldest 76 years old. Over half of the patients (6/10) had already lost both of their parents, three had lost one parent (one of these three also her stepfather) and only one patient, the youngest one, still had both parents alive. Over half of the patients came from a lower income family background. All patients had siblings, over half of them (6/10) had two to three siblings whereas one patient had nine. Two patients had lost their adult siblings. All patients had been married but one of them was widowed and another one divorced but also her ex-husband had died. Half of the patients had been in long marriages varying from 28 to 56 years and over half of the husbands in those who were married (5/8), were still working. Only two patients, both in their second marriages, had an ongoing intimate relationship with their partners. All patients, except one, had children. Nearly all the children were young adults or already in middle age with their own families. Two patients had one child, five had two to four children and two had had six children. Three patients had had full-term stillborn babies and one of these patients had also lost her adult child.

The majority of the patients (7/10) had had basic education with some vocational training and had stayed in lower income jobs. Three had had professional training. Four patients were still in full time or part time employment and the rest were retired. Only three patients had had serious physical health issues in the past before their breast cancer diagnosis. However, over half of the patients (6/10) had had some psychological problems of which three of them had been treated with medication. All this material from the questionnaires was useful for my study giving me additional information about the patients' family and life background, and context for their current situation. It also backed my original plan as I wanted to know how 'ordinary' women psychologically managed their illness of breast cancer.

Demographic Information Collected from the Questionnaires

Patients and their age	A (59)	B (63)	C (63)	D (76)	F (65)	G (66)	J (62)	K (61)	L (49)	M (55)	Average age 62 years
Deaths of both parents	-	yes	-	yes	yes	-	yes	yes	-	yes	6 patients (pts)
Death of one parent	yes	-	yes	-	-	yes	-	-	-	-	3 pts
Lower income family background	yes	-	yes	-	-	yes	yes	yes	-	yes	6 pts from lower income families
Siblings alive	1	1	2	1	2	3	3	2	2	9	26 siblings
Siblings dead	-	-	-	-	1	-	-	1	-	-	2 siblings
Length of marriage	38	-	45	56	-	48	16	17	7	28	Average 32 years
Widow	-	yes	-	-	yes	-	-	-	-	-	2 pts
Divorced	-	-	-	-	yes	-	-	-	-	-	1 pt
Partner working	yes	-	no	no	-	no	yes	yes	yes	yes	5 partners working
Ongoing intimate relationship with partner	no	-	no	no	-	no	yes	no	yes	no	2 pts in intimate relationship
Children alive	3	2	2	4	1	4	-	1	5	3	25 children alive
Children dead	-	-	1	2	-	-	-	-	1	-	4 children dead
Professional training	no	yes	no	yes	no	no	yes	no	no	no	7 pts with no prof. training
Employed	yes	yes	yes	no	no	no	no	yes	no	no	4 pts employed
Retired	no	no	no	yes	yes	yes	yes	no	yes	yes	6 pts retired
Serious past health concerns	no	no	no	no	no	yes	yes	no	yes	no	3 pts with past health concerns
Previous psychological problems	yes	yes	yes	no	yes	yes	no	no	yes	no	6 pts with previous psychol. problems
Psychiatric medication needed	no	no	yes	-	no	yes	-	-	yes	-	3 pts needed medication

4.3. Patients' Reactions to the Illness Process Based on the Interviews

In this section I begin by describing the patients' psychological reactions to their illness process. I have named the ten patients by capital letters: 'A', 'B', 'C', 'D', 'F', 'G', 'J', 'K', 'L' and 'M'. The two younger patients who dropped out after their first interview and were excluded from this study, I had named by letters 'E' and 'H'. (I did not use the letter 'I' to avoid confusion with the first personal pronoun.) I will follow here the chronological order of the patients' illness process. The five main categories in this section are 'Being Diagnosed', 'Having Treatment', 'Getting Support', 'Losses Endured' and 'Long-Term Impact of Breast Cancer on Patients' Life'. All this material I have collected from the interviews. In the end of each main category I will explore some of the patients' reactions and other issues from a psychoanalytic point of view.

4.3.1. Psychoanalysis: Providing a Way of Understanding Women with Breast Cancer

Women facing breast cancer can find themselves in disturbing and threatening situations for which psychoanalysis provides a particular insight. Psychoanalytic theory and practice lead to interpretations of both developmental and unconscious determinants when understanding the human mind. This understanding is partly based on Freud's metapsychology of the psychic apparatus and its development (which I have explained in a more detailed way in the 'Methodology' section). Freud (1959 [1925-26]) saw that certain psychological phenomena were common to all human beings. He regarded anxiety as being one of them.

Anxiety (in Freud's words 'Angst') is a reaction to danger; psychoanalytic theory understands that, besides external dangers, there are dangers that can come from within. Freud (1963 [1916-17]) regarded a realistic anxiety as being rational and intelligible. It is a normal reaction to an external danger in the real world. Freud named it as a self-preservative instinct which helps the individual to decide whether to flee the danger or otherwise defend against it. In my study, the external danger situation for the women was their diagnosis of breast cancer and its various treatments.

However, the dangers can also come from inside the person's mind, provoked by her psyche. In this kind of situation, the danger is not external but internal representing a threat to the individual's 'self'. The internal dangers, depending on the past traumas and experiences, can create 'neurotic' anxieties which are the ego's reaction to a danger. Here the ego treats the internal dangers in a similar way to external ones. Freud said that the resulting 'free floating' anxiety is ready to attach

itself to any idea that is in any way suitable to contain it. The ego can also use the defence of repression to 'push' anxiety provoking issues into the unconsciousness. 'Neurotic' anxieties could also become bound to certain objects or situations which then become phobic. In phobias the internal danger is now experienced as external. Freud (1959 [1925-26]) saw that internal danger situations, common to us all, come from several different sources. Many of them relate back to major developmental periods of each individual's life. Even though internal danger situations change at different times of life, they all have common characteristics. For example, some danger situations are linked with being separated from a loved person (at first the young infant being separated from mother), with fears of losing a loved person or losing her love. There are also fears of bodily hurt or of being helpless without a 'holding environment'.

Wiseberg, Yorke and Radford (1976) have indicated, how a developmental view of anxiety was prominent in Freud's (1959, [1926]) formulations, leading from the somatic to the psychic. The developmental line of anxiety starts from unmet early somatic needs which are experienced as physical anxieties in a time when an infant's ego is still primarily residing in her body ('bodily ego'). Later on, psychically experienced anxieties are first widespread and extensive in their nature before finally developing into signal anxieties which warn us of a situation where engulfing anxieties could take over. Even if the mother copes well enough with her infant's needs, there will inevitably be some frustrations which the infant will gradually be able to master, as her mental capacities become more sophisticated. If the anxieties are becoming overwhelming and difficult to master mentally, the child may resort to somatic defences in order to cope with the situation. However, somatic pathways to release anxieties are never lost but could be seen also in adults, for example in psychosomatic conditions. Wiseberg, Yorke and Radford (1976) pointed out that with some adults, anxiety remains widespread and it has failed to achieve a signal function. In some others the anxiety has reached the signal function, but it may be lost, temporarily or permanently, in a traumatic situation. These adults will be overwhelmed by widespread anxieties which make them feel helpless. There are also conditions, such as some psychiatric illnesses for example, where a still more primitive flooding of extensive anxieties will take over the person leaving her with minimal psychic functioning.

The diagnosis of breast cancer and the subsequent going through of its different treatments can be traumatic situations at any stages. They are not just potentially overwhelming in themselves, but the person may be overwhelmed because they arouse earlier related traumatic situations. Psychoanalytic theory sees a trauma as an intense event to which the individual is incapable of responding to adequately, and that has a long-lasting effect on the psychic organisation. The trauma evokes an influx of overwhelming emotions which the person finds intolerable and is not able to master them or work them through psychically. Dupont (1998) has shown how Ferenczi (1949) in his trauma theory emphasised the significance, for the individual affected by trauma, to have a

trusted person in the post-traumatic situation. Without this kind of support the loneliness and isolation represent a 'serious pathogenic source'. The earlier traumas, if not previously 'digested', can evoke similarly overwhelming emotions in the new edition of the situation later in the person's life. (I am using here trauma in a sense of it being something the person has not fully recovered from.) Nevertheless, if the difficult experiences in the past have been sufficiently emotionally 'worked through', they will no longer be traumatic. My observations collected in the interviews show that the traumatic experience of losing one's breast (or parts of it) arouses disturbing emotions linked with earlier experiences of loss; such as losing the caring person, losing the love of that person and losing the 'holding environment'. As I already mentioned earlier, in normal development these kinds of fears are typical of different stages in children's separation-individuation process from their parents. What is important here is that in the situations which arouse signals from within of internal danger situations, the child's fears need to be attended to and she needs to be helped to manage and process them. If there have been too many disappointments or actual traumas in these aspects of development, the growing child may gradually lose her trust in others and as a result, in adulthood, struggle with overwhelming invasive anxieties in the face of the new losses and anticipated loneliness. If the anxiety becomes excessively great, it can paralyse all actions and lead to helplessness.

In potentially traumatic situations it is normal that the individual will mobilise various defences in order to protect herself against her realistic or 'neurotic' anxieties becoming overwhelming. The main defences against the traumatic situation of having breast cancer and its consequences (such as fears of abandonment and loneliness) the patients in my study used denial, projection and regression. Denial is used when the person unconsciously refuses to accept aspects of a given reality because the acceptance would create unmanageable overwhelming feelings. Projection is used when the person gets rid of unwanted feelings by attributing them outside her 'self' and into other people or institutions. In regression the person withdraws to earlier levels of functioning in order to avoid difficult feelings when faced with a traumatic situation. In the following sections, when presenting the results, I will show examples of these defences. I have talked in a more detailed way about the use of defences under the heading 'Psychoanalytic Theory' in the 'Literature Review' section.

Freeman (2007) has shown, when investigating children's fearful responses to dental treatments, how the differentiation between realistic and 'neurotic' anxiety is very important because it provides an explanation why children's fears are different from those of adults. In my study I will show how different women managed their illness experiences and the interventions in diverse ways depending largely on their previous traumatic experiences or their abilities to manage the anxieties linked with them. I will be using psychoanalytic understanding as 'a research tool to expose the hidden factors'

behind my participants' reactions to their diagnoses and treatments. I want to emphasise that psychoanalytic theory sees all the strata of an individual's development as potentially re-awoken in current situations. Re-activation to earlier stages is called regression. Glover (1949) wrote about putting in place 'a provisional infantile government' that we regress to, in moments of great stress.

4.3.2. Being Diagnosed

4.3.2.1. Psychological Reactions to the Diagnosis

Receiving Letter

Most patients (7/10) had attended their routine mammogram screening and had not recognised any worrying symptoms related to their breasts. They thought they were healthy. But when an unusually thick letter came from the Breast Unit soon after their routine mammogram, all these women became suddenly anxious, straight away anticipating something more alarming to come. When 'K' saw the letter and it was very heavy, she thought, *'oh, this is not good.'* And 'F' described how she came back home, and the post had been, and she knew the envelope straight away. She picked it up and it was thick. She immediately thought, *'no, there's something.'* Only two patients had found the lump themselves and one patient's cancer was detected during the treatment of another illness (Appendix no 10: Referral to Hospital).

Getting News

When at hospital, 'F' was quick to pick up that there was definitely something wrong when the radiologist observed the biopsy being taken from her and how she concentrated on one particular area. 'F' said she did not ask the radiologist to tell her because she knew that she was not getting the answer. But she said, *'you must have a very good idea of what is "definite" and what is "maybe".'* 'F's anxiety was raised, and she found herself in an internal conflict because she did and she did not want to know about her situation; but as long as she did not know exactly what was going on, she could hang onto her hopes that things were alright with her after all.

There was still a disbelief in nearly all patients (9/10) when their diagnosis was given to them at the hospital (Appendix no 10: Psychological Reactions). 'A' just could not believe that it was true. She told me how Mr X looked at her straight in her eyes, focusing on her. *'And the nurse was standing behind him. With tears in my eyes, I was looking at the nurse. And then I had to focus on him again.... it was, like, "this is not happening.... this is not real".'* Even now 'A' felt that it was not real because she could not feel any lumps. Also 'C' found it difficult to take in the news because she did not have

any symptoms. She said that *'on one level, you know that there is something.... when there is something wrong. But when it comes to breast cancer...'* She never would have spotted it. 'J' discovered herself in a very similar situation because she just could not feel anything, she had *'no pain or discomfort.'*

It was as if the patients' body had somehow played tricks with them when it had not expressed any worrying signs. This was very much also 'K's' experience. She was convinced that she would have never found her cancer. *'It doesn't matter how much you say, "check yourself". This would have been never found by me.... "Are you actually saying that I've got breast cancer?". After the MRI and the results of the other area, I think that's when the reality.... when it really..... (crying).'*

Shock and Panic

Receiving the diagnosis created a huge emotional shock and panic amongst nearly all patients (9/10). 'B' had no clear idea what she was told in that situation. *'The information I was given, I have not the slightest knowledge of any information that I was given. Total memory blank. I have not a clue. I do not remember what she said. She could have said black was green, she could have said, you will be in huge pain, you will have this done to you, you will have nothing done to you. She could have told me anything. Well, my mind was not on listening to anybody talking to me. My mind was, "right, I've got the diagnosis.... yes, I've got a cancer".'* And 'F' recalled that she felt totally cut off when receiving the news and she did not show any emotion.... *'I just sat there and when he went out of the room, the nurse said to me, "right, we'll just go through a few things now. Just to let you know, you have got cancer, but it is contained". She said it twice and, afterwards I thought, was she wondering if I'd, actually, understood what she was telling me.'* 'M' remarked that she was also disconnected from her feelings, but her body was telling something different. And she said, *'I'm not overly worried but my body is saying otherwise. I'll have to cough. I think once I got that diagnosed, I've suffered from asthma and I think it is stress related.'*

And 'G' who had found the lump herself and who, rationally, should have anticipated that something probably was wrong, was temporarily 'dissociated' from her normal functioning. She said that she was not expecting anything bad but *'oh, that was a terrible shock. I'll never forget that day.'* 'G' was in such a shock that she got on the wrong bus when going back home. Her mind had been so preoccupied with the diagnosis that it disrupted her normal actions. Her 'never forgetting that day' may have offered for 'G' different options. She might have got stuck and never been able to move on from the memory of that day or she might have been able to work through her traumatic memory in her mind and finally after that, been able to move on.

'L' who had had her initial shock, understandably very soon expected the logical thing and was certain that it was going to be cancer, even though the staff members in the Breast Unit were still investigating her situation. *'I will be honest, I was very shocked when I first found my lump.... The nurses and the doctors, when I first went in, were like, "we don't know what this is". And I was like, "but I do".'* This kind of reaction may have been 'L's defence to try to take control in the face of being threatened by helpless passivity as part of her traumatic situation.

Blaming Someone or Something

Some patients were trying to allocate various explanations for their illness to render it less 'out of the blue' or to manage the fact that there was no simple explanation as to why it had developed. In 'A's mind it was her husband who was responsible for her illness as their marital relationship had recently been difficult. She announced to me that *'I can't help but think that the stressful time may have something to do with this. For eighteen months my husband ignored us in the house causing mayhem against us.... I do blame him.'* 'C' blamed herself because she had missed her previous mammograms. It had been six years since she had one. 'C' said she did not have time for it and she just ignored it.... *'So, I gave up examining my breasts. And I thought, "I really can't be bothered going under that thought". So, I hadn't bothered on the mammogram before, and I very nearly didn't bother on this one either. I mustn't ignore them again because you just don't know.'* 'F' did wonder whether her HRT treatment may have caused her illness. She told me how she had been on HRT for fourteen years and she always knew, it was a risk. *'But I took it because my life was awful. So, I went on it, and it was like being reborn. I knew it was a risk and every time I went to the doctors to get my prescription, I used to get a lecture. And I said, "well, I understand, but I'm prepared to take the risks." I was only taking, towards the last couple of years, two or three tablets a week..... but as soon as I got that letter, I never took another one.'*

Waiting and 'Not Knowing'

The final diagnosis could only be given gradually to the patients after several investigatory steps, such as surgical procedures and cellular pathology tests, had been completed. These practices give more detailed information about the type of the cancer, the number of the tumours, their stages and spread. In effect, this meant that in this initial stage the patients knew they had a cancer, but they did not yet have a more detailed information of its extent. Several patients (6/10) talked about their anxieties of being left on their own and 'not knowing'. 'J' desperately wanted to know her situation because she thought that the *'not knowing was scarier than the knowing.'* And 'M' became very frightened, feeling that she was left to her own devices when her diagnostic process took a much longer time than she had anticipated. *'When they first saw it, they thought it was only a thumbnail,*

and they'd get it. So, when they went to put the seed in, the lady who was putting the seed in, noticed that there was another lump, like a bigger lump than what it was supposed to be..... It was actually horrible, because they left me in limbo, if you like. I didn't know where I was going. I knew they sent me for the MRI scan but after that I had nothing until I had to go and see him again. And it was just absolutely awful.'

However, even the professionals were not, for a while, in a position to tell exactly the extent of the disease and the stage of the pathological cells. The realisation by some patients that the screening mammogram does not always detect all the tumours, was anxiety provoking, leaving the patient on her own in a diagnostic limbo and uncertainty. The MRI (magnetic resonance imaging) technique may be also needed to assess the extent of the disease. 'A' was very worried about her situation telling me that *'it frightens you, the fact, that it (another cell pathology) wasn't picked up on a mammogram. And the fact that I might have to wait for a tumour to develop before it's ever detected and picked up. So, if they've never picked that up, it could be anywhere. It could be somewhere else in the breast and it's not picked up. So, how long I'd been walking round with these things inside my breast going wrong... I had no idea when this had started or what caused it. And not knowing where my treatment path lies.'* 'K' was also nervous when she did not know exactly what was going on. She was concerned about the fourth area and not really knowing where it was in her breast, and assuming it was cancerous. She was concerned that it might be near the chest wall.

Very typically the final definitive diagnosis will be made during a longer process after the surgical procedure has been performed and the cellular pathologies assessed. This period of 'not knowing' the extent of the diagnosis created lots of stress amongst most patients (8/10) who were openly anxious when they had to wait on their own for the final results. 'B' thought that the information about this process would have been very helpful to know in advance. *'It possibly should have been said, "this is a two-or three-part diagnosis. At this stage, we know x, then we know y, but at stage z, that is when we know the whole bang-sheet, finally". And I don't think that package was actually said.'*

Growing Anxieties

Even though the initial results were already given to the patients, it was difficult psychologically to digest what was going on. 'A' was left a bit confused because of her anxieties. *'I don't know whether she said "locally" or not. I don't know.... I'm not 100 % sure that 9 mm tumour is classed as an early stage..... I don't know and nobody's telling me. So, nothing, I had nothing to give me a warning that there was something wrong.'* And 'K' became increasingly worried asking, *'whereabouts is the fourth area? He said, "behind the nipple, but at the back". So, that worried me, thinking that it obviously*

didn't show on the mammogram.... You know, whether it's on the breast or the chest wall. That kind of unsettled me.'

'M' had a really distressing experience when new lumps were detected. She recalled me how horrible her experience had been. 'It was like two weeks and it felt like two years. And he kept saying, "it's alright because the cancer's been there for a while, it won't grow". And I'm thinking, "you didn't even know how big it was in the first place" and it proved me right. It was a tiny lump. And all they had to do was to take the lump out..... Then they found this next lump and then another lump. There were three lumps and the cancer went from stage 2 to stage 3.... but they picked it up on MRI. So why are we getting a mammogram and why are they doing the scans if it's not picking it up? How can they only tell on MRI scan? It did knock my confidence quite a bit, to be honest.'

At least half of the patients (5/10) had fears of their cancer spreading while they were waiting for their operation. And this was very much in 'A's mind when she told me: *'Between getting diagnosed and now, for all I know, it could have spread. I keep thinking if I move, it'll spread. I keep feeling twinges under my arm, but I don't know whether that's me or whether it's my mind playing tricks on me. I keep feeling underneath here, I get twinges and I think, "oh, God, it's spreading now".'* Also 'K' had similar fears about her cancer spreading. *'When I first was diagnosed with this, I googled it and it said the brain.... and I had believed that it didn't go to the brain. I just hoped that it hadn't spread. I realised that they can treat breast cancer..... but it's just if it's spread somewhere else.'*

Intrusive Cancer Thoughts

After having received their diagnosis, a half (5/10) of the patients felt that they were now victims of intrusive cancer thoughts. The patients found themselves helpless targets of these thoughts because they could not stop them coming into their minds. 'A's mind was overwhelmed because *'cancer is, sort of, you know, in front of my mind 24/7, all the time. I sleep in till about 1 o'clock in the afternoon. I have no desire to get up or do anything or do any housework or go about my normal business. I take sleeping tablets at night to try to knock me over to sleep, so I don't think about it.'*

There were anxieties and uncertainties about the future and whether things were ever going to be all right again. The cancer was hopefully going to be got rid of physically, but many patients were wondering whether it was possible to get rid of it also from their minds. They felt very lonely in their situation. Night time was an especially powerful experience for some patients when they were lying in bed awake with their scary thoughts, preoccupied with the potential of death. 'G' found the nights very difficult because she felt desolate and her mind overwhelmed by these intrusive thoughts. *'And*

trying to sleep at night, it's the last thing you think about. I find it hard to go to sleep. I keep everything to myself.'

Fear of Dying

Therefore, in this situation, the fear of dying was in many patients' minds and several (7/10) talked about it openly. 'G' would have found it very hard if she was not seeing her family. *'If anything was to happen, you know. Not being round. I just can't imagine life without me being there for them.'* 'J' was more frightened about the way of dying than being dead. *'So, that is the thing I'd be most afraid of, something long and drawn out.... there was all that going on in my head on the first night. But when I woke up in the morning, I thought, "you're not going to die tomorrow. You don't need to do that". So, I had black thoughts the first night and then, when I got up in the morning, I thought, "don't panic".'* 'K' found her thoughts about death very difficult because *'I love my life and I love everything... but so does everybody. Everybody is the same. You think, "I don't want it to end".'* However, 'M' did not want to talk about it at all because she admitted having a very good way of blocking out these kinds of matters.

4.3.2.2. Psychological Reactions to the News about the Cell Pathologies

In this subsection of the 'Diagnosis Category', I describe how the patients reacted to the news of the more detailed physical findings following the investigations into their illness. After having received more details, all the patients (10/10) had at least some basic ideas about the physical attributes of their cancers (Appendix no 11: Extent & Grade of Cell Pathologies). Knowing about the sizes and stages of the tumours helped them to feel that they were now getting their bodies back in control. 'A' was very well aware about the properties of her tumour telling me that *'it's nine millimetres. And all they said was that it's early stages. It's hormone receptive, oestrogen receptive, positive.'* And 'D' knew that her cancer was so small that *'it was located by accident, really.'*

However, a small size did not necessarily mean good news as much was dependent on the type of the tumour. That was the situation with 'J'. *'Less than a centimetre, so it is very small. But it's stage three and aggressive..... that was a bit of a worry. But it was aggressive here and nowhere else. So that's good. I would have been very upset if it had started to travel.'* 'L' had multiple lumps in various sites. She knew *'it's hormone reactive..... and the biggest lumps were Grade 3 cancer. We expected it to be an aggressive cancer because of the way it behaved. It was eight lumps of cancer that they could detect with the eye. And they did a proper look at it in the microscope for anymore.'*

The more detailed physical findings provoked lots of anxieties for 'M' when additional growths were detected before her planned operation which had to be then cancelled. In this situation 'M' felt as if the carpet was being pulled from underneath her feet and she became very frightened on her own. She reported to me that she was terrified, *'but I was convinced, I was just going, "that lump was just bruising". For them to come back and say, "it wasn't (bruising)," knocked me off my feet and I just went like "oh!" and then he said, "well, we're not operating". And everything just went (click), and I burst into tears. I didn't have anything else to say, anything else to do. I just burst into tears.....'*

Lymph Nodes

Most patients (8/10) were fully aware of the risk that if their cancer had spread into the lymph nodes, it may have been more difficult to contain. 'A' understood the importance of clear lymph nodes from the previous experience with her mother's breast cancer. However, 'L' was left struggling with the news about her situation because of her powerful anxieties. She told me that *'there was nothing in the lymph that they took away, so that's good.... They took three. Two that looked normal and this one that looked enlarged..... but he said that it was soft..... he said that that's just an ordinary sign of infection. That's not a sign of cancer. But we did agree that to have so much cancer in that breast, the likelihood is, that it would be in the lymph nodes because it was, obviously, quite an aggressive cancer to be so big in there.... and as I guessed, one of the nodules had cancer in it.'* 'M', on the other hand, used denial as her defence when she found it difficult to keep it in her mind that one lymph node was in fact affected. *'They were taking lymph nodes and there was one.... affected. They took ten lymph nodes and there's no infection.... no cancer there. They've removed all the lymph nodes and there's no cancer.'* For most patients it was understandably a big relief to hear that their lymph nodes were unaffected. This knowledge increased more their feeling that they were back in control over their own bodies.

4.3.2.3. Comments on Being Diagnosed

It was important to note how in the first stage, following the mammogram, the thickness of the letter asking the women to attend further investigations at the hospital, became, right from the beginning, a very powerful symbol. In the women's minds something very disturbing was immediately aroused by the sight of this thick letter. As 'K' and 'F' stated, it gave them straight away a warning that most probably something else was to come and they were immediately on the alert. The women's anxiety was a further clear warning signal, like a red traffic light, of a potential trauma being present. However, this externally based realistic anxiety was an appropriate and normal reaction to the unexpected situation even though anxieties aroused by internal conflicts were also quickly evoked from within the person. Freud (1959 [1926]) defined anxiety as an affective state and as such only

felt by the ego. It includes feelings of unpleasure, and it is accompanied by physical sensations linked with certain body parts, such as respiratory organs, heart and motor reactions, many of these sensations the person is usually aware of.

Once at hospital, many of these patients, like 'A', 'C' and 'K' for example, were not expecting bad news really as they had been physically well without a slightest worry that something potentially dangerous was going on in their bodies. Therefore, the news of possible breast cancer created initial feelings of unreality in most patients and especially in those who had had no physical symptoms at all. This kind of unreal feeling was a sign that these women were using a defence of denial, an understandable first attempt to ward off the reality of the potentially traumatic situation that they were faced with. The reality of this situation would have most probably evoked overwhelming uncontrollable emotions in them.

Some patients, like 'G', for example, who found the lump herself and should have anticipated some bad news, was never going to forget that day when she got her diagnosis. 'G' was unable to find any of her usual defences to manage herself in this threatening danger situation and she started to feel extremely anxious and panicky. In a case of panic the person's usual defences that normally help her to manage challenging situations, break down. A panic can be defined as an acute stress reaction in response to some impending disaster over which the person may have no control. She might not be conscious of what the danger is but in many people's mind there is the idea that something potentially fatal is being encountered. It is important to stress here that in psychoanalytic theory panic is a sign of a severe threat, an extreme form of anxiety, towards the internal danger. However, panic is experienced also in face of external threats to one's survival. Normal signal anxiety has failed to contain this situation. Strong emotional responses, such as severe anxiety, agitation and fears, as well as somatic responses, such as dizziness, shortness of breath, palpitations and nausea, are all panic manifestations. When panicking, the adult person becomes like an anxious child. It needs to be emphasised that in a panic situation the person feels as if she is being abandoned by her caring internalised objects, left without her 'holding environment' and her ego is threatened with disintegration at that time.

In contrast, some other patients were temporarily in denial or disbelief, like 'F' for example who took the news in a very flat way and 'M' who was not really worried about her situation even though her continuous coughing was a sign that her body was affected. These patients were defending against the reality of something very serious for them; and in this situation, it was the reality of having breast cancer. These kinds of reactions were the opposite to panic because now the person was very much cut off from her feelings. In this situation, the ego protects the person's 'self' against internal and external dangers by denying and cutting off overwhelming difficult emotions.

When the patients were in this kind of 'altered' stressful state, either panicking or cutting themselves off from reality, all kinds of reassurances about treatment plans and practicalities explained by the staff members, did not seem to have very much impact on them. This was the case especially with 'B' who felt totally cut off and removed from her present situation and was unable to take in the staff members' clarifications about her future procedures. In the panicking group major reactions are likely to continue if the person cannot trust in the 'holding environment' but retains her initial belief in her internal dangers that she is going to die, regardless of other external signs that all will be well. Some others, like 'J' for example, were better balanced and trustful with their internalised caring objects. They quickly grasped that they had a good chance of surviving and getting back their health.

The situation of having sudden disturbing news was an understandable trigger to provoke overwhelming responses. Many patients told me that when they were given the initial diagnosis, they were flooded with anxieties about going to die from this potentially life-threatening illness. These sudden ideas about their mortality, provoked by anxieties linked with the internal conflicts, contained ideas that the loved objects in their minds had abandoned them (at least temporarily) leaving them to their own devices. 'J' was afraid of the method of dying but very quickly realised that her death was not going to be imminent. 'K' found it very difficult to talk about the death, possibly linked with the very recent loss of her sister and the fear of becoming identified with her sister who had suffered from breast cancer for the rest of her life. In this way cancer was very much seen by many as signifying death. Being overwhelmed by these anxieties evoked by internal conflicts, made it very difficult for there to be any room for the patients to re-find the caring objects in their minds and see the other more realistic possibilities in this situation; namely, that their lives might be saved by the early diagnosis, and the staff members in this 'holding environment' were trying hard to reassure them of this option.

However, some patients' minds did not function in the normal way when their usual defences were overwhelmed with what they experienced as devastating news. 'G' for example, who took the wrong bus after having had her feedback, had her mind totally somewhere else. The thought processes could be fragmented, broken up metaphorically like a vase in pieces. That was the situation also for example with 'F' who took in her news without feeling anything, or with 'M' who was not particularly worried even though her continuous coughing gave a different kind of message. This kind of 'disintegration' possibly had a protective function in a sense that if the patient's thoughts had been joined up, then the reality of her breast cancer would have been presented. Thus, the defensive process of 'going to pieces' in this internal danger situation prevented the mind registering and thinking coherently. Ferenczi (Dupont 1998) saw the initial reaction to a sudden trauma being a break with reality. He continued that the person may react with a paralysis of all psychic activity, of

motility, perception and thought, followed by passivity and non-resistance. The person may become impressionable and may react with fragmentation or even atomisation of her personality.

As most patients had attended their routine three-yearly mammogram and they did not have any worrying symptoms, it may have been for most of them difficult emotionally to integrate the purpose of the mammogram and the possibility of detecting breast cancer. The whole intention of screening is to intervene early if cancer was present in the hope of preventing a devastating outcome. After being diagnosed some patients made efforts to find explanations for their illness, like 'A' blaming her husband, 'C' herself and 'F' her HRT. These reasons were the mind's attempt to take back control in the absence of their own 'holding' functions and try to make sense of something for which there was otherwise no ready explanation; to fill in the gaps when the devastating news seemed to appear from 'nowhere' and the cancer was present without the person being previously aware of anything wrong going on in her body. This could be seen as a way to try to hold, with the help of these explanations, 'free floating' anxieties which Freud (1959) thought were ready to attach themselves to anything that could contain them.

The period of 'not knowing' where the patients were left, waiting for further investigations and the results of them, was a powerful time in generating growing anxieties. There were all kinds of fears and phantasies about the potential potency of the cancer. Especially when the tumours could not be felt or seen, the feeling of something happening out of patients' control, was increased. They were left with their own thoughts and being frightened that they had lost the support of their 'holding environment'. Some patients had ideas that the cancer was now living a life of its own. It was lurking there and wanting to attack the person's private body, the control of which she had now lost. 'A' for example, thought that the cancer could be already anywhere in her body. Also 'K' had immediate thoughts about cancer coming back or already being somewhere else in her body if she had any minor physical complaints. And 'M' was worried that the biopsy had contributed to her cancer spreading. When there was this kind of 'physical fear' of the body being out of control, it perhaps also brought back emotions of being vulnerable, helpless and totally dependent on others in some much earlier situations where the parental 'holding' function had failed.

I observed how the most powerful psychological reactions occurred during the first interviews following the initial diagnosis. Many patients, for example 'A', 'K' and 'M' burst into tears or were crying more openly. I suspected that this may have been the first time for a few of them that they could let their emotions come out in this way. 'G' told me that she only cried on her own at home because she did not want to disturb her husband. This showed the rawness of the situation but also, especially in the case of 'A', 'G' and 'M', how many of these patients felt being left emotionally to

their own devices and could not rely on their supportive 'holding environment'. I will come back in a more detailed way to the emotional loneliness in the following sections.

4.3.3. Having Treatment

The next stage was for me to explore the treatment category and how the patients managed the different treatment methods that included surgery, radiotherapy, chemotherapy and endocrine therapy. However, not all of these were allocated to everybody. All the patients underwent surgery but only three had chemotherapy and most women received radiotherapy, followed by endocrine therapy.

4.3.3.1. Surgery

Wanting to Know

As just stated, everybody had a surgical procedure and it led to a variety of emotional reactions. All patients (10/10) had at least a rough idea of what kind of surgical procedures were going to be done to their bodies (Appendix no 12: Surgery). Four patients had found it helpful to obtain a more detailed knowledge about their forthcoming operations which may have increased their feeling that they were in more control over themselves. This information about procedures is given automatically for all patients. 'A' was well aware what was going to happen in her operation. *'So, I think it's a case of I'm going to have some fat taken away from underneath this arm with some blood vessels and an artery, and I think I'm going to have it transferred into there.'* This kind of 'practical' knowledge was also very important for 'J' helping her to be in control of the situation. 'J's experience was now very different from her previous major operation many years ago. She explained to me how she would be either cut round the nipple or cut under the arm, or they would do one cut down the side. *'And that was to be decided just before the surgery because I'd been injected with some radioactive substances as well as having the little radioactive lead in. And when I was in the pre-op, they had an ultrasound Geiger counter thing, and they were working out where everything was that they needed to see. And then they drew little arrows and things on us for where they were going to go.'*

Not Wanting to Know

Only two patients (2/10) did not want to know about the details of their forthcoming operations. 'G' did not ask any questions and probably was at denial of the reality of her illness. This may have been her way of protecting herself from any further anxieties. She told me that she was not thinking

of the cancer. *'So, I just don't know anything. I don't really ask a lot of questions. In a way, I don't want to know, you know?'* And 'M' tried to distance herself as far as possible from any thinking. *'I don't want to know what you're doing. Put the needle in, do what you have to do, freeze it, take your hits, but don't tell me..... When he said, "we'll just roll the muscle up and we'll just turn it round". And I went, "that's enough information for me, don't tell me anymore. Just do what you have to do". I can't look at needles. I can't watch them taking blood. I don't want to know. In pre-op they just insist on telling you everything, even though you say, "please don't, I'm squeamish". I'm saying I don't want to know..... I was really mad. I'm horrified. I know myself. I can't deal with that and I'll be sick.'*

Anxieties about Forthcoming Operation

Even though the information about the surgical procedures was given to everybody, a half of the patients (5/10) were still left anxious about their approaching operations. 'A' was somewhat confused about the whole thing and did not know what she was coming for. *'I didn't know whether I was going to have the breast off or whether it was good news that they'd got clear margins or whether they were going to do a re-excision. I had no idea. With getting the letter prematurely, not knowing what I was going for, was a silly mistake for a patient who is virtually on the ceiling about the whole issue.'* 'K' was already very anxious about the time following her operation as she was frightened of being left to her own devices. She expected to be out of action for a few weeks and it was going to be Christmas. *'I'm in and out the same day. I was a bit shocked at that.... It's just kind of, "oh, my Goodness. I'll be at home". There'll be nobody there. I just mean there will be nobody there, medical, you know.'*

And because of the medical reasons, it was necessary to shrink 'G's' tumour with endocrine therapy before the surgical procedure. She was left waiting for her operation for about nine months which she found extremely distressing. *'I just want it over with. It's just like something alien inside you, "I don't want it there. I don't want it; I don't like the thought of it being there".'* Not being able to get rid of the alien frightening 'thing' in her body, made it even more difficult for 'G' to have any peace of mind and trust that this was the best approach in her treatment.

The breasts had always been an important part of 'L's' body, in fact the only part, she thought, that people had liked in her. She became agitated and felt attacked by another doctor who gave his 'second opinion' about her surgical procedure. The idea of losing her whole breast was felt as a total devastation by 'L' and almost like a repetition from her past when she was abused, and others decided what they wanted to do with her body. 'L' told me straight away in her first interview about her experiences of being abused as a child. This had become, in a way, a part of 'L's' identity. So,

in the hospital situation she was terrified of not being in control and could not trust in the others' good will to help her when she was dependent. 'L' felt as if the carpet had been taken from underneath her feet. *'This doctor tried telling me that he wanted to do a simple mastectomy. This means that you don't have a breast at all. I said, "I am sorry, but you can't". And I couldn't get through to him that that was not an option. I said, "if you do that, do not wake me up because I do not want to be left with one breast". I would feel like a freak. I was like, "I can't deal with this". When the doctor was suggesting leaving this breast as it was and just reconstructing this other breast, I felt almost very much back to being told that they're going to do something against my will. He's just focused on, "this is what I'm going to do, and you don't quantify for a say". It's very much back into that abusive situation that "you're not in control of this. We are going to do what we want to you". He wasn't listening, and he wasn't understanding, and he didn't want to hear me.... but every woman is going to feel a bit apprehensive, worried, unsure. We should remember that really. They need to be nurtured a bit (crying).'*

Own Decision

Quite a few patients (6/10) talked about how they had a choice to say what kind of operation they wanted to have. The experience of being more in control over one's own body, in this way, should have helped to decrease at least some anxieties. 'F' found it difficult to make that decision. She recalled how the consultant had told her that it was her body. And if she had needed a mastectomy, he would have just told her that, but now, she was free to decide herself. Also 'G' was able to make her own decision with some help *'but he said that I could change my mind any time if I want to.'* 'K' had witnessed what her sister had emotionally experienced following her breast cancer operation. So, 'K's decision to have mastectomy with implant was purely because of her sister.... *'because my sister found it a nuisance having a prosthesis.'*

Operation

The operation was mentioned by all patients, but mainly in a very brief way and quite positively. 'D' told me how it almost felt unreal when everything happened so quickly. Because of a long distance she left home at 5.30 am and her daughter took her down. But she never went to the theatre until after 12 noon. *'Then I've got a feeling I was on my way home by about 5 o'clock. So, I was back home, and it just felt unreal. It was strange because I didn't feel anything. I didn't feel as though I'd had an operation. I just felt that was quick and that it's over.'* And 'J's operation was also completed without any problems. *'Everything went well, just as it should have. I left the same day, yes. We were here for 7 o'clock in the morning and it was after eight o'clock at night when we left.'*

However, 'M' experienced her operation in a very dramatic way. As if she was like a condemned person, her crime being that she had cancer. She described me how terrified she was..... *'And when I went to this operation, it was like the walk to doom. They made me walk to the operation theatre. It was horrible. It was like, dingy, dark corridors that tend to go on for miles. I went, "am I there yet?" and it was like, "no, it's just round the corner". Pushing doors and this, that and the other. And I thought, "oh, my God, I know how people felt when they're getting their heads chopped off and they had to walk to these things". Poor Mary Queen of Scots, I thought. It was horrendous. That was the worst. And my legs began to shake, and.... "eeh"..... I said, "oh my God, what"... It was the most horrible experience in your life. And then to walk in there and two lads standing with needles, and I'm not good with needles, saying, "are you alright? Just jump onto there". Well, I didn't just want to jump onto the bed. I wanted to turn round and run the opposite way... '*

And interestingly, 'L' who had had a bad initial experience in the Breast Unit, had a very positive experience of her operation and she felt looked after on the ward. However, there was a relief when she was 'released' from hospital back to the safety of her home. *'Mr X popped round in the afternoon, as well, and I was sitting up and he was like, "oh, I can see you're fine!" He said, "of course you can go home". It was like, "brilliant".'*

Unpleasant Ward Experiences

However, 'F's experience on the ward was the very opposite as she found her stay very 'noisy' and some staff members behaving inappropriately. *'My goodness, it was like being on a night out in X. They had the doors open, I was right next to the station, and I was on the end bed. And it was just constant, all through the night. At one point, I think they did close the doors for a few hours.... but then, in the morning.... is it the ward support workers, they were in the brown uniform? My goodness, it was just horrendous, I'm going to write in, actually. They were just chatting amongst each other, from one bed to the other, what they'd been doing. And I couldn't stand..... I asked for a bedpan, and it was, "has anyone seen the bedpan? I think it's in that cupboard". And I was thinking, "my goodness, this is awful". And she didn't put it in the right place, so... I thought, this is awful.'*

And 'B' criticised the hygienic standard of the ward she was staying in. This added her anxieties of getting infection (which she actually got in the end). She recalled how her drain came adrift, came apart, which she reported. *'I told the nurse. She pushed it back in without cleaning it, without sterilising it or anything like that. I said, "aren't you supposed to clean it?". "Oh, no", I thought. "Well, it's done now. What do I say now? Do I report?" I was so in pain.'*

Recovery

Most of the patients (8/10) were surprised to find out that even though the operation itself was quick and straight forward, their recovery from it was not at all easy and their recuperation time was sometimes much longer than they had expected. In that process there were further surgical procedures for some, to ease the pain. 'B' was suffering from considerable pain in her breast and her whole body. *'So, what they had to do was to change the painkillers to increase them against the pain because I had morphine on the ward, but they couldn't allow me to have morphine at home. So, they put a bigger strength painkiller in and took out the codeine which I'd been prescribed. Unfortunately, I was back again at A&E on the following Monday. When I first came out, I really did not know where I was, what I was doing..... I was like zombie because I had such a high level of pain and..... I took all the painkillers I could, to the maximum that I was allowed. Once they'd grown the cultures, it turned out to be a seroma that had become infected.'*

Several patients were suffering from soreness, swelling and leaking of the breast or they felt some lumps which alerted them to the dreaded idea that there were still other tumours somewhere else. Many were suffering from different kinds of muscle and nerve pains which they thought were linked with reconstructing the breast by using a flap from another part of their bodies. 'F' told me how she could not put her arms by her side. And *'I had to lie flat on the bed with arms like that, just up. It was like electric shocks going shooting through my breast, to the nipple, just shooting through; it was obviously the nerves.'* Also 'K's anxiety levels remained very high. She concluded that her implant was more painful than she expected it to be. *'I've got quite a big swelling above the implant, it's very hot and sore, and my arm is more sore..... I've never had this before; this is a new problem. I thought having the implant would be a quick fix..... but it hasn't been easy. It's sad but I do feel as if it's taken over my life..... They only took two of my lymph nodes and they were clear. So, if they took ten, maybe.... You know, so your mind is going... I hope they took enough. I've got a swelling here and I hope cells weren't left behind.'*

'M' was suffering from pain, but she was also convinced about her own phantasies that the multiple cancerous lumps which were detected at the end of her diagnostic investigation, were a result of surgical procedures. *'All I feel is pain, like I've been hit with a bus. The pain was just terrific. I phoned the doctor to get some stronger painkillers because the painkillers I was taking were not working. They were not doing anything to numb the pain. I never expected this much pain from under the arm. My body has been punished. I ended up three lumps at the end if you remember. And I said I'm sure when he cut into that one, it spread which gave me the second one. And when they took that out and took the biopsy of the other one, you're getting three lumps in a spread and that is the thing with cancer. I'm surprised they even let him do it. Because I know, if you cut into cancer, it*

spreads. That's a mistake because I think it just spread so quickly from that tiny lump... The minute you cut into cancer; it spreads. That's what my brain tells me. I should have said, "don't take the biopsy".'

Few patients experienced severe problems with the dressings because some of the nursing staff were not familiar with them. This caused even more pain and extra suffering, as 'F' was to tell me. *'I came up, and saw one of the nurses, and the first thing she said, was, "I've never seen these dressings before"..... She said, "I don't know if these are ready to come off". So, I said...." I didn't know either". Anyway, she proceeded to take them off and it was horrendous. So, I took an Ibuprofen and a paracetamol together (at home), but as the afternoon went on, it just got worse and worse. It was horrendous, honestly. It was quite traumatic.... and I was totally on my own. I was actually pacing the floor, with pain. So, I rang the Clinic up the next morning, at 9 o'clock, because I had hardly slept. There was an answering machine, so I kept ringing. And then I left a message, and nobody got back. And then it was about two or three hours later when I actually got through and explained what had happened. I said, "I just want to know if this is normal, because I've never been in such pain. And I said, "everybody commented about the dressings". So, she said, "perhaps you needed those dressings". And I said, "I don't know, it was just awful. I just want to know if that's normal". And she couldn't even answer, she just said, "I know it's not pleasant, having the dressings off".'*

'J' fainted when her dressings were taken off. The physical pain in this minor procedure possibly brought back all the 'old' physical and probably psychological pains linked with her previous cancer experience of 40 years ago. Indeed, 'J' had told me in another connection that she first started to faint whenever small medical procedures were done to her in connection with her previous experience in her late teens. Fainting in this present situation could have been 'J's body's way to physically cut her off from some previous psychologically painful memories. She told me how it was very uncomfortable having the dressings taken off because everything was sticking. *'And I fainted with pain. I think it was just stuck on so well and dried on, and it was stuck onto the stitches. So, when she was pulling the plaster, it was pulling on the stitch as well, and I could feel it.'*

Feeling Lonely with One's Body

After the surgery some patients felt that they were left to their own devices with their fragile and sore bodies. 'A' felt very lonely and unsupported and she was hoping that somebody could have looked at her breast *'because there's a lump here and there's a lump there and whether that's normal. I do contact the breast care nurses and yes, they can talk to you over the phone. But they say there's nowhere where you can walk in and just say, "can you have a look at that?" You're left with that on*

your own. Yes, they probably try and console you as much as they can. But who is to say there might be a seroma there? There's nobody who can give me that reassurance.... I would just like somebody to say, "look, that is fine". Also 'B' needed more support. *'A listener, not necessarily to take my mind off it but to actually put it back in perspective, slot it back into life.'*

4.3.3.2. Chemotherapy

Fears

Many patients were dreading of the possibility of needing chemotherapy before the radiotherapy treatment. Chemotherapy was administered only to three patients (3/10) but two of these patients had to discontinue their treatment because of various physical complications (Appendix no 13: Chemotherapy). The chemotherapy provoked lots of anxieties and fears in advance. The three patients, 'J', 'L' and 'M' were worried about various side effects like losing one's hair, nausea or even the treatment itself, leading to vulnerability to other cancers.

'L' speculated the risks of having or not having this treatment. The only apparent consolation for her was that it was going to last for a limited length of time. She was aware that *'the chemotherapy is a carcinogen and causes cancer. So, it's kind of damned if you do and damned if you don't, to be fair. So, if you don't have it, you run the risk that there's some cells that have escaped and will restart..... I think it's not like it's forever. I don't know how long each course lasts. I just know it will be 18 weeks altogether. So, I'm dreading it but I'm prepared for it and, as I say, I think it's easier to take on board because you're like....."well, chemotherapy, my hair's going to fall out, I'm going to feel awful on certain days of the cycle. But it's only eighteen weeks".'* And 'J' found her internal strengths to think positively as a way of coping and was very practically orientated. She wanted to ask about the side effects, about the frequency and how it was going to be administered in order to see if she could prepare herself for them. *'You have to think positive.'* Whereas 'M' was clearly struggling in this situation because she did not want to do the chemotherapy at all. *'I just said, "no, I don't want to do that". My daughter then burst into tears and said, "you have to. Mum, you've got to. You've got to give yourself the best".* 'M' was very frightened as she had seen her twin sister going through this treatment and having a breakdown.

Losses Associated with Chemotherapy

So, it was not only the loss of breast these patients had endured, but chemotherapy meant also other kinds of losses. Losing one's hair seemed to be the most sensitive issue, even though the patients had tried to prepare themselves to that in different ways, all of them having acquired a good

wig in advance. The hair loss was most threatening for 'L' because she felt she was going to lose also her positive identity. This threat was related to her being frightened that she would be then exposed to others' critical look. 'L' explained how she had spent hundreds of pounds on getting her hair right, and it takes so long to grow. She was 'super nervous' about losing her hair. However, she had found a wig, close to her own hair and thought that she was prepared as much as she could be. 'J' was again able to be positive by taking control over the situation. *'We were very upset when my husband had to take my hair off. We went upstairs and he took it off with..... they're like shears, electric shears, and he shaved my head. I said, "oh, that's that, we're in control, we have taken control of that now". Before he started, he said, "this is a very difficult thing for me to do". And I said, "it has to be done". You have to have a laugh about it. Otherwise you would just cry.'*

Experience of Chemotherapy

'L' who already had had a distressful experience in the Breast Unit where she felt her needs were misunderstood and ignored, was again faced with upsetting experiences with the staff members in another hospital. She strongly felt that her vulnerable areas, due to her earlier experiences of being abused, were again overlooked and not understood. The intrusion into her body by the medical procedures were again experienced as a forceful violation by her, even though these very people were trying to help her. She described me how *'the nurse, when she couldn't get the cannula in, she wasn't even talking to me. She was just stabbing away at the back of my hand. And I am so bad with needles and then they're like, "you should have told us". I went, "I did, it's all over my notes". It's quite sad that they have to highlight on my notes that communication is needed. Dr Y, and she's a woman, was like, "can I check your breasts". "Why? You're doing the chemotherapy". "Well, I like to have a look". And I felt properly violated. Just completely violated because I didn't want that to happen and she was almost insisting that that was going to happen..... We're back to what she wants. It just increased my feeling of being violated. And probably because I've been raped in the past and I've had the sexual abuse and everything else.'*

The physical experience of going through chemotherapy was much worse than the patients had anticipated. That was the case even for 'J' who tried to hold onto her positive outlook. *'The drugs they give me for the anti-sickness, they had to give me additional ones... they make my face swell up like a big red balloon. I don't look. I look away. I don't like needles at all. I tend to pass out at the sight of them. I am very, very tired. I feel very smelly..... I don't know if it's the chemicals. It's like a taste and a smell. I've had one scary incident. I woke up in the night with a very sharp pain in my left-hand-side, and I just disregarded it. In the morning, when I got out of the shower, and I was drying myself, I had a black line down here and bruising. So, I had to go to hospital and the doctor said that one of my veins had ruptured.'*

Infections and pains were the reason why both 'L' and 'M' interrupted their treatments after the fourth session. 'L' found the whole experience very distressful. *'I was scared about having the chemotherapy. And everything I dreaded, and worse, happened when I actually had it. I was so ill, you know. I've had the nausea and the sickness. I also got an infection. That was horrendous. I've got four lots of anti-sickness tablets. Then I had shingles. My veins were collapsing, and I had a line infection. My temperature was going up and I was ill. Then Mr X came round and saw me on the ward and it was decided that I had done four lots of chemo, my line had to come out because it was infected. I had the start of sepsis.'*

And 'M' told me how her whole body was suffering. *'I'm not doing any more chemotherapy. After this last bout there, I've just said that's enough because I feel that my body's had enough. The pain, it was unbelievable. As I said to you, I couldn't even speak.... pain everywhere..... in my legs, my feet, my back, my chest. Every area, which way you name it, I had pain. I didn't know where to put myself. I'd phoned up and said I wasn't feeling too well, and they said, "just take Paracetamol". I said, "look, the Paracetamol and the Codeine aren't doing anything. I'm still not getting any relief from the pain". It's definitely been hard and very emotional, and it's all just hit the brick wall. I burst into tears. And of course, it's the infection that's got us, but I didn't know. When I phoned up to X they said go to Y and see if it's an infection. And it was an infection.'*

4.3.3.3. Radiotherapy

The radiotherapy created different kinds of worries but not on the same scale as the surgery or chemotherapy. Most patients (7/10) were advised to have radiotherapy, usually a few weeks after they had completed the surgery and the wounds had healed (Appendix no 14: Radiotherapy).

Those Who Did Not Have Radiotherapy

Three patients were not recommended the radiotherapy option. 'K' who was not offered this treatment, was left on her own questioning the reasons why she did not have this recommendation. She recalled that she was told that if she had a lumpectomy, she would have radiotherapy. But because she had the full mastectomy, she did not need that treatment. *'But it seems that a few women who have had the mastectomy, still get radiotherapy... and I don't understand. I wouldn't want to think I've put my life at risk through having the implant, but I think they would have still done the radiotherapy if I'd needed it, and then that would have obviously run the risk of damaging the implant.'* Whereas 'C' was advised to proceed with radiotherapy but decided not to take up this recommendation. She explained to me that *'they reckoned that there was a 15% chance it could reoccur. Radiotherapy would reduce that by half. But I'm a "glass is half-full" person. So, I think an*

85% chance it won't come back, rather than 15% chance it will. They said they would try very hard not to damage my heart. And there was a small chance that it might inflame my lung. And I thought "well, it wasn't really worth the risk". So, I decided against the radiotherapy.'

Worries about Radiotherapy

All women talked about their understanding as to how radiotherapy works. A few patients felt quite anxious about the risks this treatment may pose, especially the possibility of increasing risk of another cancer or of it harming internal organs close to the treated breast. 'A' was somewhat confused about why she was given radiotherapy and worried about this treatment causing another cancer. She explained how she was told that *'it's classed as adjuvant, which I think the popping it in is additional, meaning they're doing a "belts and braces" job. So, my initial thought was, well it's because I've got some cancer cells there, or maybe. She said, "no".... that's not why I was getting it. That's what she said. But you can't help but think, "is that the case". I don't know. It's trying to sort out if there's any loose cells about. But also, it might create another cancer. So, I'm, like, in the middle.'*

The time taken to travelling to the treatment every weekday for three weeks was a worry for 'C' and 'D', but for slightly different reasons. 'C' who refused to have radiotherapy, was worried that the travelling was going to take a big chunk of her working day even though she lived locally. *'And then by the time you go in, get ready, have the therapy, come out and then come home again. You're probably talking about three hours by the time you're finished.'* However, 'D' was prepared to endure her long journey. *'All this up and down to X, 3200 miles, when you've finished. I thought if the cancer doesn't kill me, the travelling will kill. I was so exhausted every day.'* Once in the treatment room, a few patients experienced the preparations for the treatment very frustrating when the staff members were trying to position them in the right way, and it took often such a long time to do this. 'F' described how she was there for ages and they just couldn't get it right. *'So that's been the hardest bit rather than the actual radiotherapy bit.'* Also 'G' had a very similar experience when it took a very long time setting her up and when they were going to take pictures, the machine had broken down. *'I just had to lie there whilst they got the technicians in to fix it.... I was there for about 50 minutes. I couldn't feel my arms when I brought them down.'*

Experience of Attending Radiotherapy

The treatment itself did not cause any major problems for most patients (5/7). 'D' even found it a bit enjoyable when she received attention from a young male staff member who looked after her treatment. *'I did go a bit funny, when I thought of this young man, C, placing my breast where he*

wanted it to be. I thought “think of England”. But he has developed this relationship, “do you like my music”. I had to go into another treatment room and C came with me and said, “she has to have her music on. This is what she likes”. They are very caring. Very friendly. Very cheerful.’

Seeing Other Cancer Patients

Nonetheless, the most difficult issue for some patients, was going to the other hospital for radiotherapy and having to see there other cancer patients who were in a much worse situation than they themselves. ‘D’s experience of this was very powerful and she described her worries to me. ‘It was just seeing people sitting round at all stages of cancer and I thought to myself, “I don’t belong here. I’m alright. I’ve got to get out of here before I catch something”. Have I gone through this to get more cancer, which I feel I can pick up off from other people sitting there. I feel it’s contagious. Up until then, the cancer was not worrying me.’ Also ‘G’ found her experience quite disturbing. ‘Yes, it’s terrible with some of them. There are tumours coming out here and there. It was disturbing.... When you see them all at the hospital, it’s terrible. There are all sorts there and I have been very lucky.’ It was painful for ‘F’ to have her radiotherapy in the same hospital that she had taken her father for cancer treatments. ‘I had been in the same hospital because my father, you know, he was only 60 when he died. He had lung cancer. And the hospital was relatively new at that point and when I went in.... it really brought back those feelings from a long time ago and a sadness that this goes on all the time.’

4.3.3.4. Endocrine Therapy

Majority of the patients were aware towards the end of their other treatments, that they were going to have endocrine therapy (hormonal treatment), which will lower their oestrogen levels connected with breast cancer. The patients were going to receive this treatment for five to ten years, depending on the nature of their illness. The potential side effects of this treatment, such as pains in the body and hair thinning, created lots of worries and anxieties in the patients. Those five patients who already were receiving endocrine therapy, all talked about it in a negative way (Appendix no 15: Endocrine Therapy).

Losses Associated with Endocrine Therapy

‘A’ was very alarmed that she was going to ‘lose’ her hair. ‘Out of all side effects that I was reading, what came to the forefront is alopecia.... you could get alopecia! I’m going to lose my hair. “Oh my God! This is a deal breaker”, I can’t be doing this. So far, I’ve been lucky enough to avoid chemotherapy where you lose your hair. And now it’s gonna get us in the tablet form. Well, in the

hormone tablet. I think it's one in ten that you can get hair thinning. I must be vain, that's all I can say..... because I could have been one of these people that were sitting there, and they said, "there's nothing more we can do for you, it's terminal". And 'K' was frightened of aging prematurely, losing her own familiar identity and being changed into somebody else. *'I don't feel the same person at all, you know.'*

Aches and Pains

After having started their endocrine therapy, the patients (4/5) suffered from significant distressing problems like various pains, aches and hot flushes. 'B' was suffering from these a great deal. She had *'hot flushes, any time of the day, any place, anywhere.'* Also 'G' struggled with different kinds of pains and nausea. *'My arms are still very bad. But he changed my medication and course. Now I feel sick all the time. I get a lot of joint pain with the medication, so I can't walk far. I get very tired. I get terrible sweats and flushes all the time.'* And 'K' said she felt older, *'stiff and achy. Just aching. I find that in my hip and my thigh.'*

4.3.3.5. Comments on Having Treatment

Psychoanalysis in Understanding Surgery

Surgical procedures can evoke quite different responses between one patient and another. These responses could be understood in relation to each individual's internal psychological resources. In the first group there are patients, who, when faced with surgery, seem to regress into being completely dependent, almost like young children, on external resources and passively accepting everything that is said or done to them. They do not want to think or know details of their treatment plans or take any active role in decision making regarding their surgical procedures. These patients find it difficult to trust in any internal mental resources in themselves. The second group will include patients who have a capacity to make use of the external environment, to depend on external help and to trust in the professionals' decision making. This is because they have secure internalised caretakers, a capacity to find 'good enough' internal figures in their minds which is helping them to trust. These patients have had 'good enough' early environments and parental figures who have helped them to digest difficult emotions. The third group would contain patients who, because of their traumatic past experiences, cannot find 'good enough' reliable internalised caretaking figures in their minds. The internalisation of un-trustworthy or hostile caretakers is then re-projected onto the outside world and as a result of that these patients feel hostile or threatened by any procedure and not able to trust in help that is offered to them. These categories are broad and overlap considerably but we can see some of these traits in the patients in my study.

Intrusions into the body such as those aroused by the idea of cancer and its treatments may well create powerful anxieties. The origins of these anxieties can be linked with earlier traumatic experiences when the body has been impacted from outside. Winnicott (1965a) emphasised the importance of 'impingement' by the psychic environment and its responsibility for the infant's 'continuity of being' and emotional health. The first environment for the infant is her mother. The 'environmental mother' offers a facilitating environment which enables the child to grow and this process usually leads to mental health. Whereas a damaging environment, especially in the beginning, is more likely to lead to mental ill health. If the infant has good enough ego-support from the people around her, she will gradually learn to meet the 'impingement' by her environment and as a result will strengthen her self-awareness and trust in the people around her. However, too early or too intense 'impingement' can be traumatic. If the environment is not accommodating to the infant's needs but on the contrary, she needs to accommodate herself to the environment, the infant will use defences, such as withdrawing herself and not responding to people, in order to protect herself against the environment that has let her down. This may end up the adult person being left helpless and distrustful in the future.

Surgical procedures are often experienced as forceful 'impingement' into private and sensitive aspects of patients' bodies and therefore they understandably provoke a mixture of powerful thoughts and emotions, particularly in the area of trust in the environment. It was noticeable how the patients managed in a variety of ways the issues of trust, which were related to the anticipated intrusion. This was linked with their internalised caring objects in the childhood and how trustworthy these objects had been in the past. In the hospital situation the staff members were acting as 'loco parentis'. Some patients were able to trust and put themselves in the staff members' 'hands' which in a way helped them to manage themselves. This was the case for example with 'J' who relied on the professionals' ability to make the right decision of her surgical procedure just before the operation, and 'D' who felt straight away that she was in the safe hands after being disappointed with another hospital. Some others like 'L' and 'M' found it difficult to hold onto their faith that the professionals knew what they were doing, and instead they experienced being left alone and helpless with frightening phantasies. They saw themselves as victims of some staff members and projected their own negative feelings into them. This was the case with 'L' who found it difficult to trust and easily felt being 'attacked' by some professionals. Some of her hospital experiences were felt like repetitions of her previous traumas of being abused. She felt that the rug was being pulled from underneath her feet when she experienced that the doctor who gave his second opinion about her operation, ignored her standpoint. She had clearly expressed to him that a simple mastectomy was not an option for her and if that had happened, she would have not wanted to be woken up. In that moment 'L' had lost all her good objects. Whereas 'M' lost her confidence in the surgeon when her initial diagnosis had to be changed. She was convinced of becoming victimised because the

surgeon operating on her (when taking a biopsy) had cut into her original cancer which then, in her view, spread as a result of this operation. In this situation 'M' had lost trust in her good internal objects and felt that she was left at the 'mercy of neglectful and harmful' others.

Many patients, like 'A' and 'J' for example, wanted to know more details about their forthcoming operation; knowing these details possibly helped them to feel that they were getting back more control over their bodies. However, even though 'A' received many answers to her questions, she could not rely on the 'holding environment', by which I mean the staff members who were giving this information. This was probably because of her major anxieties and difficulties to hang onto her good internal objects who would have looked after her. It was very important for 'J' to know what was happening to her because in her previous cancer treatment as a very young woman, she was told hardly anything. It was understandable that the lack of information in the past must have made 'J's' experience very disturbing and frightening. Asking and being aware of all what was now happening to her, must have been 'J's' way also psychically to repair some of her traumatic past experiences.

On the other hand, there were also a couple of patients who did not want to know any details about their forthcoming operations. 'G' did not want to ask any questions because she simply did not want to know, and 'M' found it disturbing if any medical procedures were explained to her and she did not want to hear about them. This was these patients' defensive way to block out their anxieties and frightening thoughts (probably linked with some earlier fears) that the intrusion into their bodies would have otherwise provoked in their minds. 'G' and 'M' had used here the defence of distancing in order to cope and protect themselves in otherwise a too difficult anxiety laden situation. However, the question remains whether this defence succeeded to help these patients to manage their anxieties in the longer term and what were the implications if they did not look at the possibilities of their long-standing situation. As we can see in the following sections, the past experiences which have not been worked through in a person's mind, do not lose their emotional power but often tend to encapsulate in the internal world where they are kept separate from the rest of the person's psychological functioning but could suddenly erupt by a suitable trigger.

The Operation

The actual operation, after it had happened, was mentioned by all patients in the interview and interestingly, most women touched on it very briefly and in a matter of fact way. Probably having this kind of rational outlook without emotional aspects helped them to manage the situation. A few patients, like 'D', 'J' and 'L' for example, were positively surprised and relieved that the whole procedure was done so quickly and their stay at the hospital was minimal. 'D' felt it to be almost unreal when everything happened so quickly. The overall feeling was a relief when they were rid of

the frightening 'thing'. In 'G's situation, where she had to wait many months for her operation, the cancer was like a foreign intruder in her body, probably also a reminder of her mortality. Both 'L' and 'M' were very frightened of needles. This left me questioning what other more unconscious frightening ideas in their minds were withdrawn from consciousness and attached to the phobias of these particular objects; the needles.

After the Operation

After the relatively straight forward and quick surgery in the hospital where some patients were operated as day-patients and others stayed overnight, the post-operative period after discharge turned out to be much more distressful. In this situation there were fears of losing that caring and 'holding environment' which the hospital had offered. Many patients felt that they were now left to their own resources with their still fragile and sore bodies. 'B' for example was suffering from a considerable pain in her whole body. This created a situation in which all kinds of phantasies came into the patients' minds about what might be still going on inside their bodies. For 'A' and 'K', it was like a persecutory state where the cancer had a life of its own and it had not left their bodies in peace. 'A' was worried about the nature of her lumps and 'K' about whether some cancer cells had been left behind. The strange experience of being left alone with one's now unfamiliar body because a lump or the whole breast had been removed, was striking. This was the case for example with 'K' who felt that she was not the same person anymore and with 'M' whose whole body was suffering because it had had 'enough'. Some of these very powerful experiences may have been partly linked with some earlier struggles where these patients had been frightened and vulnerable. In the present situation caused by their illness, their 'self', the feeling who they were, was now threatened. The incidents from the past being 'repeated' in the present situation was seen for instance with 'L' who experienced, in her internal world, some of the medical procedures as abuse, as repetitions of her earlier struggles of being abused. Also 'M' experienced that the surgeon made things worse for her, rather than benefitted her. She was convinced of her own unrealistic phantasies that her cancer had spread because it was cut. This kind of idea may have been an indication of some other disturbing experiences in her past. It was interesting to hear that her twin sister had had a serious mental breakdown some years ago and that breakdown in 'M's mind was caused by her sister's breast cancer treatment. Therefore, it was likely that 'M' was now threatened with becoming identified with her sister. Her cancer treatment was now associated in her mind with her sister's and this situation caused worries about her own physical deterioration and her own psychological vulnerabilities.

In this situation, the patients were looking for caring objects and clearly needed support and understanding. They wanted to share their worries with staff members. 'A' and 'F' for example would have needed reassurances that their certain post-operative concerns were normal and fine, and 'B'

would have wished somebody to be there and put everything back in perspective. The physical illness and associated dependency were bound to provoke some regressive wishes, such as a childlike longing that somebody else could have pulled the patients back to reality and comforted them that they were safe.

Other Treatments

It was not only the loss of breast or parts of it that the patients had to endure. The research interviews indicated that some of them anticipated that the treatments following the surgery would bring some further physical losses for them. Uncertainties about the future in general may have been also projected in this way into the treatments which caused other kinds of misgivings. The idea of having chemotherapy was dreaded by many. 'J', 'L' and 'M' to whom it was administered, were frightened of it causing physical suffering, nausea and vulnerability to other cancers. The loss of the hair, and related to that, fears of losing one's familiar appearance, were the most sensitive issues, even though these patients tried to prepare themselves in different ways. Especially for 'L' the hair loss would have meant losing her positive identity from her appearance and becoming some kind of public spectacle for others, a 'freak' or 'cancer victim'.

Radiotherapy caused a dilemma in the minds of some patients because they feared its risk to 'damage' their healthy bodies at the same time as it was destroying the possible cancer cells. 'A' and 'L' were worried about this treatment causing other cancers and 'C's concern was that her heart and lungs would become harmed. However, having to go for this treatment in another hospital forced the patients to see other cancer sufferers who were in a much worse situation than they themselves. This brought back painful memories for 'F' about her father's cancer treatment in the same hospital and 'G' found it disturbing to see so many people with advanced cancers. 'D' became anxious and wanted to run away because she had phantasies that the other patients' more advanced cancers were contagious, and she would have caught them by being in the same room with these patients. This was a kind of magical irrational thinking that one's thoughts as such are powerful enough to make something happen. When seeing these other cancer sufferers, the patients' worst fears and uncertainties of their own future and mortality were aroused into consciousness. It had been difficult for them previously to recognise their own worries but in this way and by not being able to distance themselves from seeing these other patients, they became in touch with their own anxieties about ending up in a similar kind of situation. Also, endocrine therapy was seen for some patients as taking away their old familiar identity and active body; fear of losing one's 'hair', having aches and pains and aging pre-maturely, were the most usual worries. The fear of 'B', 'G' and 'K' was to become vulnerable and fragile for the rest of their lives.

4.3.4. Getting Support

In the 'Getting Support' category I will now explore what kind of assistance was available for the patients and how it was utilised by them. The sources of potential support were the patients' partners, their other family members and friends, the staff members in the Breast Unit and at the hospital, and work colleagues. I also included a separate category for 'Emotional Loneliness' when the patients did not feel that appropriate kind of support was available for them.

4.3.4.1. Partners

Most patients (8/10) were married with husbands. 'B' was widowed, and 'F' was divorced, but her ex-husband had also died (Appendix no 16: Support from Partners). The diagnosis of breast cancer and its treatments clearly had an impact on the husbands.

Practical Help

Many patients (5/8) reported that there was a clear change in their husbands' outward behaviour in a sense that they were now much more involved with all kinds of practical household duties which was quite a new situation for many of these women. It may have been that this was their husbands' way of saying, without words, how much they appreciated their wives and were worried about losing them. 'A' had some practical help from her husband, such as *'he'll make the tea and he'll do a bit of tidying up. He'll do a bit of washing.... and he'll bring a cup of tea up or a bit of toast up.'* Whereas 'C' felt that she was almost spoilt. *'I've got to say, all my favourite food has appeared on the table, for the past couple of weeks.'* Also 'G' had lots of good experiences. Her husband had been 'marvellous'. He would not let her do anything, not even making the bed or hoovering up. This made 'G' to think that *'I'm not an invalid, but.....'* 'J' was also very pleased with the practical help she had received, saying that *'he's just been off for three days and he's done all the running round, the shopping, the hoovering and all that kind of stuff. So, I'm quite the lady at home (laughing).'*

No Emotional Support

However, it seemed to be that though practical support was available and clearly appreciated, emotional support was less often offered. This came up very powerfully as nearly all women (7/8) experienced their husbands as not emotionally available, distancing themselves not only from their wives' feelings but also from their own. 'A' felt very much that she was left emotionally to her own devices and she told me: *'I said I was frightened, or something like that. And you know, "what happens, what if...." But he said, "well, how long do you wanna live for?" He's quite a big problem*

in the support or the lack of support that I have. I remember when I first got diagnosed and I sat speechless and dumbfounded on the settee and my husband went on the computer to look for a car. If he sees these feelings and worries in me, he gets annoyed. You can't be as open, and you can't be sitting there looking for feedback and confirmation and understanding because he gets just annoyed.'

'C's experience was very similar. She told me that *'if I tried to talk to him, he really didn't want to. He really didn't want to go into detail about this.... he didn't want to know.'* And 'D's husband could not even use the word 'cancer' and he could not cope with it at all. *'He has a bad heart..... and he puts his head in the sand and talks about other things. He can't talk about cancer. He can't use the word. Well, he's 83 next year and I suppose he's still in his childhood thing. When people had cancer, they died. As soon as I start talking about it, he just changes the subject. My daughter said that he's only worried about who's going to look after him if I died.'* Also 'G' had this kind of experience and she explained how her husband could not even say the word "cancer". *'He would always say the "tumour" or the "thing". He doesn't show his feelings anyway. So, you don't know with him.'* And 'K's husband did not express himself either. *'He doesn't say too much. He doesn't give too much away. He's very quiet, you know.'*

Patients Looking After their Husbands

The husbands were putting up a front of being in control, not showing their own feelings so as not to upset their wives and most probably themselves. This situation when the husbands withdrew themselves and did not want to talk about the distressing issues, made the patients worried about them. And often they themselves ended up protecting and looking after their husbands' emotional states.

'J' knew that her husband was worried but *'he keeps saying, "everything'll be okay. Everything'll be okay". He's putting a positive front.'* 'C's husband took the news very badly and *'he went into a sort of panic. He doesn't say a lot.... But it's been a bit of a shock to him.'* Whereas 'G' told me that her husband does not express his feelings apart from the day when he received the news. And then *'he was just devastated. I've never seen him like that before..... uncontrollable. He was terrible. Just the thought of it upsets me now.... He was crying and shaking and just couldn't believe it. So, I just don't talk about it to him, because I know he gets upset.'* 'J' had somewhat similar experiences with her husband and 'J' told me how he took it much worse than she herself. *'He was in a great deal of shock. He gets very upset about it. He's quite sensitive about things.'* Also 'M' told me how her husband was very upset with the news. *'He was sort of really, really worried. He was sitting and*

crying. The minute I cry, he says, "don't you cry because you'll make me worse".... It upsets him if I cry.'

Husbands' Own Losses

It turned out that many of the husbands themselves had had their own losses, some of which were very recent ones. 'A' told me about her husband's very current losses. *'Well, his mum died of pancreatic cancer last year. And he used to go and see her virtually every night.... And he lost his brother last week or the week before. So, we've got a funeral to go tomorrow.'* And 'G' told how her husband had lost close family members. *'His mother had had cancer as well. And he was only one year old when his father died.'*

4.3.4.2. Family and Friends

Support from Children

Nearly all patients (9/10) had children, all of them already young single adults or in middle age with their own families. In all families there was, to some extent, positive support coming from at least from one child (Appendix no 17: Support from Other Family Members & Friends).

'A' was receiving support from her daughter. *'My daughter has tried to be there for me. She'll come and take me out and she'll send me photographs of the little one.'* And 'F's only child, her adult son, had been helpful and coming in the evenings. *'So, he's been making me something to eat.'* 'G' had a very good experience as she felt very supported by all her four children. *'Oh, my daughters came straight away. My children are marvellous, always there for support if I need them. Even the boys wanted to come rushing up, you know. And I said, "no, no, you've got your own families".'* Also 'L's older daughter was able to support her mother even though she *'doesn't do feelings very well.... but she's booked the day off work and she's come round. She takes me on the Monday for the chemotherapy and we go on Mondays to get my line flushed together.'*

Children Withdrawing

However, the patients often reported that their children's responses were rather mixed and in the same family different siblings had reacted in very different ways. Many patients (6/9) described how difficult it was for some of their grown-up children to get emotionally more involved and how those children tended to keep themselves at an arm's length. 'A' had been disappointed with her eldest son who lives just around the corner. *'Never once, he has come round to see me. They tend to take*

the lead from their dad. So, if their dad says, "she's not dying". They're like "mum, what are you going on like that for? You're not dying". 'B' found it difficult to get any substantial support from her two adult daughters and the younger one had even denied that she had ever heard about her mother's cancer. 'My younger daughter.... she's lost a lot of weight.... she was scared. She knows fully well on the consent form that one of the downsides is possible death. My elder daughter has been on the sick leave since I went in..... The younger one, thought in her head, "yes, have the operation, and everything will be okay". She maintains I didn't tell her when the operation was going to happen. And she maintains that I told her it wasn't cancer. And then, once I did tell her the final diagnosis, that there was a small amount of cancerous cells, she swears blind that I didn't even tell her about that.'

Also 'L's son had distanced himself from his mother's illness. 'L' told me how *her 'son was like, "I'm not speaking to my mum because if she doesn't tell me, I don't have to know the cancer's there. I can pretend it's not there". 'M's eldest daughter found it also difficult to be more involved with her mother's situation. 'The eldest isn't talking about it, full stop..... but she's asking the other ones, but not from me. She says she doesn't want to upset me. I don't know (coughing).'*

Patients Looking After Others

In 'D's family the anxieties were concentrated on certain family members and 'D' ended up looking after them. *'I would say, my daughter is under more stress than what I am. She had to go to the doctors because she can't sleep ... because she thinks I'm going to die. She says, "if you die, I've got nobody". She would ring me up two to three times a day. Especially the second breathing problem, she was convinced that it was secondary cancer. She's had marriage problems..... She suddenly saw me as dying and she'd be left with her three children. My son in Y, he gets a bit worried. And my other son in Z, well, he thinks I'm going to die as well. He's anxious because he's my husband's son and my husband's anxious.'*

And 'F' was very worried about her adult son who had already lost his father for cancer in his adolescence. *'I was worried more than anything telling my son..... because he lost his father ten years ago. He had a bit of a panic attack. He got such a shock, you know, because he has got no brothers or sisters. And so, I am the only one in that sense.'* 'J' who did not have her own children, ended up looking after her younger (adult) sisters because her worry was that her present illness was now associated in her sisters' minds with her previous cancer experience decades ago. *'When I was 18 and poorly, my sisters were all younger than me and they saw it all. They have memories of that time when I was ill, which are pretty bad memories. And so, they have that concern. So, I'm*

trying to reassure them with all the things that the doctors reassure me with, saying that it will be different this time.'

Friends' Support

For most patients (8/10) the support coming from their friends and neighbours often turned out to be most important. Probably it was easier for these people to be more openly involved because they did not belong to the immediate family and were not emotionally attached to the patient in the same way. 'F' very much appreciated her friend's help. *'I mean like my friend who has come today... she insisted on taking me to the hospital that morning, and she knocked on my window at 6.30 in the morning. And she sat with me, because I was one of the last ones to go down. It was lunch time when I went down. It's a long wait, and she sat with me..... So, it brings out lots of different emotions, because I think you realise who your friends are..... the ones that you can really rely on. That you can ring up, because me being so independent, I try not to. I think that's probably one of the hardest things for people if they have got nobody to help them.'* Also 'M' was lucky to have a caring friend who brought her *'up today and she brought me up the last time. She's a very good neighbour.'*

Others' Helplessness

However, some patients had experiences that support from other people was not really meant for them but served more the others' own needs. This may have been their only way to tolerate their own helplessness in that situation. 'F' thought that it was difficult for some people to make room for another person's worries because it makes them feel awkward. She told me that *'a lot of people, they don't know what to say. So, they start telling you about other people they know who've had it. Straight away, they're like, "oh, my other friend has just had..." So, they completely push yours to one side. But I think that's because it takes the awkwardness away from them somehow.'*

'J' found it hard to have her grieving sister-in-law around because her husband's sister who had lost her husband for a brain tumour, *'was very, very upset..... She comes round our house and she cries. I understand why she's crying but it's not helpful to me. She's still very raw from her husband dying and she's frightened that I'm going to die. If she hears the word "cancer" that straight away means that'*

'M' thought that other people might say some positive things in order to calm themselves down. She explained to me that she had not coped as well as she had thought she would. *'But everybody's said, "you're coping really well". And I'm like thinking, "where, when and how". I think they're saying it to themselves because they're not convincing me, you know.'* 'K' was quite pessimistic about other

people's support, saying that *'most people probably think, "well, it's over and done with you, now. You know, get on with it". Even my own family probably think like that.... I don't know.'*

4.3.4.3. Staff Members at the Hospital

Parent Figures

The staff members in the Breast Unit were often experienced by the patients as being almost like omnipotent parents who were able to fulfil the child's wish to have her problems sorted out. Nearly all patients (9/10) reported very positive experiences about the staff members and many found it extremely important that things were explained in detail to them. Getting that information did increase the patients' feeling of being safe (Appendix no 18: Support from Hospital Staff). 'A' was ready to say that after all, she had appreciated all the help given to her. She did not want to forget how lucky she was, how grateful she was *'of the doctors and nurses and everybody involved, yourself included.'* Also 'C' had had a good hospital experience compared with her earlier ones because *'everyone was at great pains to explain everything, in as calm a way as they possibly could. Whereas, thirty years ago, you were just a piece of meat.'* 'F' had felt safe, right from the beginning, and as soon she had spoken to Mr X, she knew straightaway that she was *'in good hands'*. Despite her difficult experiences with the prolonged diagnostic procedures 'M' had also positive things to say. *'Everybody's been lovely, I don't think that's an issue. I've got no complaints with any of the ways the doctors have handled anything.'*

Not Being Listened to

However, half of the patients had also some critical notions. 'B' had issues about her 'after care' treatment about which she felt very angry with the hospital but also with her local council. I questioned in my own mind whether in fact her fury was more linked with her experience that she was being left on her own without any emotional support at home because she was a widowed woman without any able adult family members around. 'B' had felt stuck after her husband's death and probably her anger was more unconsciously linked with him being absent and leaving her to cope with everything on her own. *'The surgery was fine. The actual attention within the ward and the post-operative has been wonderful. What has been absolutely dreadful, has been the discharge. And that was caused by lack of people reading notes beforehand and asking me. My husband has died, "now hang on, am I going to be able to live here". Looking at the notes that I'm 24-hour carer. My caring job is this and my other life is that. How am I going to marry that with that energy taken away from me? I think one of the problems I will have, is the fact that I have no one to share the household duties. I don't know what physical restrictions I will have. They can't say exactly, but a*

general framework would have been so useful. I asked on ward, and they said, "oh well, you can't vacuum". That was the stock answer. I'm still angry of the lack of forethought, listening and connection skills. There was no general game plan, should we say.'

When 'L' was given a second opinion about her surgery, she felt strongly that her feelings were ignored, and she was left unsupported on her own. However, later on, she was able to understand how these upsetting experiences at the hospital brought back to her mind her childhood experiences of being abused. *'The doctor realised that he was coming across very wrong. As I say, his attitude "I want to do this". There wasn't any.... "if we did this to you, how would it make you feel" or "I don't agree with that part. I think this should happen, but what do you think". I know that's wrong to feel like that. But I feel when people say things and do things like that... I find it really personal, probably, because of my past experiences. It is like a slur on me and an attack on me, personally. So, it's important, I think, that the doctors, who are absolutely amazing in the surgery, in the theatre, remember that actually they're talking to people with feelings rather than just... We don't wear a sign, "I was abused" or "I suffer with this". But surely in that situation, knowing that every woman probably is vulnerable, who is sitting there.'*

'K' and her daughter were left somewhat disappointed and without support because the other hospital was not able to test whether her cancer had hereditary origins. *'Because we don't have enough family history for a test to see if the gene is there. I just feel as if your life is literally in their hands now because it's up to them whether my daughter finds out if she is at risk or not.'*

4.3.4.4. Work Colleagues

Due to the age range there were not many patients who were working currently (4/10) and most of these four who were still in employment, had plans to retire in the near future (Appendix no 18: Support from Work Colleagues). The patients found it difficult to trust that people at work could have any understanding of their circumstances. Particularly 'C' was worried that her situation was not going to be recognised and supported by her employer and she could end up having to leave her job if she took too many periods of sick leave, and especially, if she was going to have the radiotherapy treatment. In her mind 'C' could not allow herself to be needy and trust that the hospital would have supported her in her right to have this vital treatment. She explained to me that *'if I had to go back and then be off again for the radiotherapy, then it would cause problems with my sick allowance. Then it becomes two sickness periods. And if you have three sickness periods in a row in 12 months, then you would get a warning..... I would get an oral warning because I had then two sickness periods and then if I had flu or something before the end of May next year, I would have another warning. I could be sacked.'* Also 'K' anticipated that there was not going to be any support

for her in the office. *'You know, some of the women at work might be thinking, "well, come on, you're sorted out, snap out of it", sort of thing. But it's not that easy, it's not just a switch. I think for someone, if it hasn't happened to them, it must be easy to think, "well, you've had the operation, you know, you're sorted out, you're fixed".'*

4.3.4.5. Emotional Loneliness

Nobody to Turn to

Despite the available support, which was usually more practical than emotional, it was alarming to discover that almost all women (9/10) felt that they were lonely, deserted and emotionally left to their own resources (Appendix no 19: Emotional Loneliness). There was a sense of this loneliness being cumulative, and it did not seem to decrease even though many of the treatments were ending. There were not different types of loneliness, even though the individual's circumstances varied from one person to another.

Over half of the patients now felt that they had acquired the identity of a 'cancer victim' and their husbands, especially, tended to take a step back emotionally, even though trying to be helpful on a practical level. For example, 'D's and 'G's husbands were frightened even to use the word 'cancer' and preferred to call it 'the thing' or 'it'. The word 'cancer', even when it was not verbalised, had almost an evil power in these husbands' minds. It was as if they had regressed to an earlier developmental level where the words have got a magical power. This kind of magical thinking is normal for children, for example in a situation where a child has phantasies that her aggressive thoughts have caused her parent's illness or death. By not mentioning the word 'cancer', it was as if the husbands could thereby defend and protect themselves against the reality of it. It seemed likely that there were also phantasies that their wives' illness was contagious. As I mentioned in the previous section on treatments, this was the case also with some patients themselves when they went to radiotherapy in another hospital and saw patients with more advanced cancers. Having heard these kinds of scary phantasies from the patients themselves, made me think that some of these husbands might have been in fact frightened to catch their wives' cancer if there was any emotional, let alone physical contact with them. Psychoanalytic theory and clinical experience understand that this kind of thinking is also common amongst people suffering from obsessional neurosis. They tend to avoid touching and physical contact with others with the fear that it will evoke 'dangerous' feelings (either aggressive or loving) in themselves. So, probably being in closer contact with their wives might have triggered more powerful emotions in their husbands.

The Husbands' Own Losses

At least half of the patients mentioned that their husbands had experienced different kinds of traumas, some more recent and some from the past; 'A's husband had lost his mother for cancer very recently and his brother died during the period of the interviews. The mother of 'J's husband died recently and 'G's husband had lost his mother for cancer and his father died when he was a young child. 'D's husband was elderly with a serious heart problem and frightened of the idea of his own mortality because he did not want to attend funerals. 'D's husband was also worried about who would be looking after him if something happened to his wife. This is an example of his fear of losing his caring object in 'D', and interestingly, he had had very early losses in his own life spending some of his childhood in an orphanage. 'C's disabled husband had lost his normal mobility in an accident and probably was also worried about losing his caring object in 'C'.

So, the husbands' powerful fears of their wives' cancers may well have partly been based on their own experiences of their past losses from cancer or another illness which had had a traumatising impact on them. If these losses had not been adequately grieved by the husbands, then the unresolved emotions from the previous traumas could have been provoked by their wives' illness in a powerful way. Thus, being emotionally involved in their wives' distress might have been just too overwhelming again for some of them and they regressed temporarily into an earlier stage of functioning. 'A's husband became annoyed or retreated to his laptop if he saw his wife worried, whereas 'M's husband started to cry if his wife was crying. 'G's husband had a very powerful initial reaction to her news and 'G' had never seen him like that before. He was totally out of control, 'crying, shaking' and unable to believe the news. The husbands were now struggling with their own difficult emotions trying to keep them at an arm's length. This probably had an even more disturbing impact on the patients, and they ended up, like 'C', 'D', 'G' and 'M' for example, looking after their spouses. Probably, by focussing on their husbands' inadequacies, they tried to keep their own emotional vulnerabilities inside themselves or to project them into their husbands.

Cancer brings the spectre of death, a taboo subject, and as Heidegger (1926) puts it, we turn away from our own demise and engross ourselves in the everyday mundaneness of life as if to escape. It was as if the women were now an embodiment of death and for a husband to embrace her was like to embrace death. This situation where the husbands had their own problems, was confusing. In those who are emotionally more secure, husband and wife would be looking after one another rather than both projecting their problem into the other; that means seeing one's difficulty rather exclusively in the other person.

Children's Contribution

Similar kind of 'distance taking' happened also with some of the adult children. This reminded me of Schoenberg's (2007) notion that some family members tend to withdraw themselves from the patient and thus make her feel even lonelier with her illness. In 'B's case her younger daughter was protecting herself against the fear of losing her mother, her caring object, by denying that 'B' had not even told her about the cancer diagnosis. And 'L's son had a 'safe' way to keep himself away from any distress. As 'L' stated, her son had told his girlfriend that if he did not speak to his mother, then she did not have a chance to talk about her illness and he could just pretend that 'it' was not there. So, in this way 'L's son was protecting himself against the frightening idea, the reality of his mother's breast cancer and the fear of losing her. Some of these children possibly thought that their mothers should not have been distressed in a situation where these kinds of upsetting feelings are pretty normal.

In many families there was no space for painful feelings. Keeping their mother at arm's length and 'not wanting to know' may be also explained by the children's fear of their own helplessness when they were not able to ease their mothers' distress. On the other hand, it was difficult for some of the patients to allow their adult children to be emotionally involved and become upset. The children struggling with their own feelings would have created pressures in the patients' minds that now they needed to look after the children and carry some of their children's anxieties about losing their mothers; 'B' was now looking after her two adult daughters who struggled to be more helpful to their mother. 'D' was worried about her anxious daughter and son, both of whom rang her daily, her daughter sometimes two to three times a day. 'D's daughter had recently separated and was alone with her young children. She was very anxious and frightened of being left totally without support if 'D' had died. 'F' was concerned of her adult son who had lost his father for cancer ten years ago. 'F' assumed that her son was now frightened of losing her and being left totally on his own as he was the only child. 'L' ended up looking after her adult daughter who had moved back home to look after her mother. However, 'L' was pleased to do that and perhaps it suited for both of them and helped 'L' to manage her loneliness.

Left with Emotional Loneliness

Many patients found their loneliness something negative that they needed to keep inside themselves, away from others. However, the situation where the patients ended up looking after the others, their husbands, children or other family members, was probably the only way for some of them to look after their own vulnerable needy aspects and 'lonely selves'. By projecting their own needs into others, probably helped the patients, at least to a certain extent, to manage their

unbearable loneliness which was provoked by the illness and the fears associated with it. It seemed to be that these feelings had to be kept away and there was no space to share them with others. The experience of emotional loneliness when being distanced by their husbands and by some of their children, was very powerful for nearly all patients.

'A' was frightened of her cancer being fatal and she described her situation to me in a very painful way. 'A' in her mind was now in a narcissistic lonely stage, with nowhere to go and left to her own resources. And she told me: *'When I go to hold my husband's hand, I'm frightened, and I've told him that. But he never comes to me and gives me a cuddle or just a hug. I think if there's one thing I do need, is support. And I'm crying out for that. But I feel very much alone and frightened what's gonna happen to me and whether I'll survive this horrible disease. The majority of the time you've got nowhere to go with your fears. So, you end up crying on your own. It's fearing for the future.'* Here we can see how 'A's previous losses of her beloved grandmother (and also her father and her stepfather) most probably became alive again and left her crying.

In contrast, in 'C's family the fear of cancer being fatal was experienced by her family members. 'C' told me how her family had been so stressed and upset that she could not really sit and talk to them about her illness. And trying to talk to them just made things even worse as they did not want to hear about it. *'And having heard the word "cancer", they just thought that it has got to be more serious than you're telling them.'* It is difficult to know how 'C' was trying to tell about her illness to the family, and whether her family was carrying some worries that 'C' herself did not want to own and had more unconsciously displaced them into her family members.

'F' who had lived on her own for many years, found it very difficult to talk about her illness to anybody and ask for help because this would have shown that she needed another person. Being now needy due to her illness might have possibly loosened 'F's defences against wanting companionship but she denied her neediness because it would have meant 'weakness' for her. *'My friend just rang me up to see if I was alright, and, of course, as soon as I started talking, I was crying, I was....I said, "I'm just in so much pain". Yes, I had to keep going, I had to keep doing.... what I would normally do. I'm so used to being on my own... I find it very hard to ask for any help.'* And 'G' felt her loneliness especially at night time. She did not want to disturb her husband who had found the news very shocking. When she went to bed, the last thing she was thinking about, was her cancer. *'And I can feel the tears come up, and it's in silence.'*

At one point, 'L' found herself in a very lonely and dark place. *'I can take my own life and when I'm not coping, means that that's my default position. It's like, "that's okay, I'll end it. I can't cope with this, that's it, goodbye". It's a bit weird that I go from that to here, where I am doing all these things*

to prevent myself from dying. But after the chemotherapy, I was like..... my other son that died, and I was like, "I just want them to come and take me. I can't cope with this". That was the only time when I was in the real dark days with this, having had the chemo, and then the infection. And I was so ill (crying)... 'L' did not elaborate on this further, but she was very unwell physically and probably in a state where she had lost all her 'good supportive objects' and the idea of death would have meant liberation from all her sufferings and a reunion with her stillborn baby; the dead baby boy who was daily in her mind.

And there was a confusion who was about to 'collapse' in 'M's family. 'M' felt she needed to be strong for them and not show her difficult feelings. Her fear was that if she expressed any feelings to her family members, they would 'just collapse' as she believed that they were not able to listen to her and take in her feelings. 'M' could not trust that she had any 'holding environment'; by which I mean any idea that her own family members could have helped her. In this way 'M' unwittingly created for herself a lonely situation with all the distress and struggle to cope. In fact, she was the one who was not strong but close to 'collapse'. *'So, I just don't do it. I'm very emotional, I cry at the least thing but.... my family just say, "oh, take a couple of Paracetamol, you'll be alright. You'll be alright next week, mum". But I'm not right now. That's the hard bit.'*

Positive Loneliness

Nevertheless, at least some patients (4/10) realised that being on their own did also have some positive factors as they could cope by themselves and did not need others' presence all the time. These patients perhaps had found some helpful internal figures and inner strength to be alone but not to feel excessively lonely. 'D' did not feel lonely, linked with her strong faith which functioned as a good internalised object for her. She announced to me that she was alone but not a lonely person. *'I like being independent. I like being me.'* Also 'J' liked her own company saying that *'sometimes, I just want to lie down and not have anybody there. I'm quite independent, that way.'* And 'K' had always needed her own space. *'I'm just quite happy in the house in my own little bubble, really. I've always been happy with my own company.'*

The capacity to be alone, to be in a state of 'creative loneliness', is different from loneliness where the person feels separated and isolated, totally on her own, even though there are others around her. In the 'Discussion of Results' section I will come back in a more detailed way, to the concept of loneliness which was one of the major findings in my research.

4.3.5. Losses Endured

The presence of the past was very noticeable in the interviews. It was as if the loss of breast or parts of it had brought up all kinds of experiences of other losses into the patients' minds. It is very important to note here that in the interviews I did not especially ask about these issues with the patients, but this topic came up spontaneously. The losses were either physical, as for example losing a person via death, or psychological, such as the loss of a relationship. In the 'Losses Endured' main category I have included as subcategories patients' own past illnesses, those of other important persons as well, previous deaths, experiences leading to a loss of an important aspect of the person's identity and of relationships. I will return later to the concept of losses in the 'Discussion of Results' section in order to understand it from a more theoretical point of view.

4.3.5.1. Patients' Own Illnesses

These were the different illnesses the patients had previously suffered from. The illnesses may have included physical losses, like the loss of one's fertility or the loss of an organ such as one's womb, or they may have been psychological losses if the illness meant losing a capacity to function normally, for example in depression.

Previous Cancer Experiences

Half of the patients (5/10) reported having had previous cancer related illnesses linked with pre-cancerous cells or a cancer itself. These disorders were detected and treated in their early stages. The patients brought up these, often difficult struggles, in a prominent way (Appendix no 20: Patients' Own Illnesses). 'A' told me about her previous cancer threat when she had had advanced pre-cancerous cells of the cervix which were then taken away. *'So, I did manage to put that behind me, to a large extent. But I don't know whether it was because it was pre-advanced cancer cells and not cancer cells, that I was able to do that.'* And 'C' recalled how she was desperately trying to manage her fears of dying and her inner loneliness by overeating, when a lump was found in her breast 30 years ago. *'I went to the doctor, and they said, "we'll have to do a biopsy". And the doctor had come round on the day of the operation and he said, "well, we'll take you down for the biopsy. We'll check it out, and if it's cancer, you'll wake up with one breast". I was pretty frantic then. My weight ballooned up because I just kept thinking, "well, if I want to have a chocolate bar, I'll have a chocolate bar, I could be dead this time next year". I just let myself do anything. It would have been a benign lump these days but in those days, they said it was just a lump. I also had abnormal cells.... what do you call it, when you have.... when you have the smear.... so, I had all the treatment for that.'*

'J' had a very difficult cancer experience in her late teens, and she felt that nothing was explained to her. In order to manage those difficult situations, she had developed a habit of fainting even if minor medical procedures were done to her. She recalled how she had Non-Hodgkin Lymphoma. *'And I had also a tumour inside of my chest which was twisting round my windpipe and it was slowly closing it. I was 18. And I was just 19 when they started chemotherapy. My hair was in very poor condition, but I didn't lose it. But I was very sick all the time. I was told that I wouldn't be able to have children. Not because of the cancer, but because of the chemotherapy. So that never happened. Nobody ever told me anything. Nothing was ever really explained. When I was having blood taken or when I was having anything injected into us, I would faint.'*

'F' went through a very recent cancer scare which luckily turned out to be a false alarm, in the end. The growth in her finger was a melanoma but *'there's different types of melanomas. But they said it wasn't malignant..... I had a worry of that because I started to think, "is there something else coming out".'* And 'G' had previously had a cancer of womb, many years ago when she was 28 and then a year later, she had a hysterectomy.

Other Illnesses

'G' had also suffered from psychological problems. She shared with me how she had gone through a bad depression time. *'I just couldn't go into work, couldn't face anyone. I was on antidepressants. I'm on a mild form now, for anxiety.'* And 'C' mentioned her 'terrible cough' which was very much present in our interviews and she put that down to her *'smoking, probably.'*

4.3.5.2. Other People's Illnesses

Over half of the patients (7/10) recounted various past or present serious illnesses or health conditions amongst their existing immediate family members and members of their extended families.

Cancers of Other People

Strikingly, many of these complaints were linked with other types of cancers. Altogether, three patients, 'A', 'G' and 'M', talked about eight people, currently close to them, who were suffering at the moment or had suffered in the past from one form of cancer or another (Appendix no 21: Other People's Illnesses). 'A' told me about her mother who had had a breast cancer but *'she didn't have any lymph gland involvement at that stage. And she's still with us.'* In 'G's extended family there were lots of current cancer worries around. She explained how a week after her own diagnosis, her

'daughter-in-law was diagnosed with cancer in the neck, stage three. And of course, I've got my cousin, his wife, I think hers is terminal. She's got lung cancer... and another cousin, he's just getting over cancer in the jaw.'

'M' had endured very painful and frightening cancer experiences some years ago with her twin sister and many years ago, with her young daughter. 'My twin sister, exactly five years to the day, had found out she had breast cancer. She had her breast removed. I was very worried for her (coughing)..... I was with her all the way along the line. I know my sister had her lymph nodes taken. And she did have cancerous cells in hers. She had a mental breakdown because she in her head knew that there was something wrong (coughing). She was sectioned, it was a really bad breakdown..... And my middle daughter when she was four. I'm going to choke here... I had to be then strong for her.... she had cancer in her brain stem. So, obviously they couldn't operate but it was caught very early.... if you could have changed a thousand times with the little one, you would, as a mam. You are not going to want to see your little one in pain. If you could, you would swap places. My daughter does have now hearing difficulties and learning difficulties, to a certain extent, but it hasn't impacted on her life. And my niece's daughter..... that's had a brain tumour.... and my other niece had cancer in her jaw, the same family.'

Other Physical Illnesses and Conditions

Other physical illnesses and conditions were also mentioned. 'B' told me about her adult daughter who had not been able to progress into a more independent living due to her many physical and psychological problems. *'My daughter has got a long, long list of ailments. A lot of it is allied to physical conditions of eczema, peanut allergy, muscle loss caused by anxiety, post-traumatic stress disorder, OCD, very low body weight and very low self-esteem. She lives with me and I'm her carer as well.'*

And 'C' had concerns about her disabled husband and her elderly demented father. She told me that her husband *'can get about slowly because he had damaged the whole of the left side of his body.... and because he's been walking about slightly dragging his left leg, he's now got arthritis in his right knee and in his right hip. Whereas he can potter about, he cannot walk for any length of time. And I have my dad to look after, as well.... his short-term memory has gone.'* Also 'D' was worried because her husband could not cope with her cancer diagnosis at all. *'He has a bad heart. He needs a quadrable bypass and they can't do it because of his age and because of his heart... I worry about him, yes.'* And 'G' needed to look after her elderly, nearly blind mother who was coming up to 89 and *'the only thing why I came back to this country, was to look after my mother.'*

4.3.5.3. Previous Deaths

In this subcategory there was an astonishing number of deaths, either of close family members or members in the extended family.

Deaths Related with Cancer

All patients talked about deaths and nearly all of them (9/10) mentioned deaths related to a variety of cancers. All in all, 27 deaths from cancer were reported by the nine patients (Appendix no 22: Previous Deaths). 'A' had a very disturbing and frightening experience in her early teens when her grandmother was dying of cancer. 'A' had also had another more recent cancer death when her mother-in-law died but the earlier incident with her grandmother had stayed very powerfully in her mind. *'My grandmother had... she had tongue cancer. She had operations and it spread to her neck. They gave my grandma 18 months and my mother looked after her. But it did have a huge impact on me. So, she died at home. I was thirteen years old. I was still in my school uniform and I went down to see her.... and I was focussing on the wall. She was pure skin and bone. I was pretending to look at her. God knows what she would have thought. Ever since then, I think, I've had a phobia of cancer of the tongue. It must have had a psychological effect on me somewhere.... Well, and my husband's mum died of pancreatic cancer last year.'*

'B' had lost her husband some years ago. During her husband's illness she had to carry lots of worries because she believed that she was the only one in the family who was told the terminal nature of his cancer. She recalled how her *'husband died of acute lymphoma... eight years ago. Once it was diagnosed, he actually had two and a half years of extra life. It came on suddenly, very aggressively. He wasn't told it was palliative, I was the only one who was told that.'* And 'D' had memories about how she lost her both parents for cancer. *'My mother died of liver cancer. She'd had ovarian cancer and she'd had this thing called radium treatment, when I was about four years old. So, she got another twenty years after that.... and then it just returned. My father, he was in his 80's. He died of prostate cancer.'*

'F' had lost quite a few close family members for cancer. *'My son.... he lost his father ten years ago... for lung cancer, just before his 17th birthday. We were divorced with my husband, but we remained very good friends. I helped to look after him, because he was at home until the week before he died... I had a brother, and he died when he was 37, of cancer. That was terrible. That was probably one of the worst things that we had to go through. He had a massive tumour.... they said it was the size of a baby's head.... that was very traumatic because my father had just died. He'd only been dead for four months. My father died when he was 60. He had lung cancer..... And*

my cousin died three years ago. She had breast cancer, but it had gone into her bones. My mother died four years ago; she was 91. She had a perforated ulcer, she had two blood clots on her lungs, and.... she had breast cancer.'

'J' talked about a family member and a friend who had recently died of cancer. She told me that her 'husband's brother-in-law had a brain tumour and died. Then her friend's husband who was a very fit man, died of bowel cancer.' And 'M' was memorising how her father died many years ago. *'Dad went when I was 20. I'm not sure what happened with my dad. He was in hospital for a long time. I don't know what it was. It wasn't cancer, but he deteriorated in the same way as a cancer patient.... but I don't believe it was cancer. He went downhill very quickly. He had a lump on his back, but my dad refused the operation. We never ever found out what it was. My dad wouldn't have said what it was, but he was terrified of cancer.... I hate the word "cancer". Yes, I do hate that word.'*

'K' had very painful and frightening memories about her mother's death many years ago. She had also lost her older sister very recently. This sister had had breast cancer but died of emphysema for which she refused to have treatment. 'K' recollected that their *'mum died when she was 53. She had lung cancer and a brain tumour... she had had cancer all over her body. My older brother and sister told me that she was "riddled", that's a horrible word, but that she was "riddled with cancer", so it was all over.... She had always smoked, and she was chesty. I moved back in, and we looked after her. And we didn't have a nurse in until about three days before she died. I never actually acknowledged that she was going to die, and she never acknowledged that she was going to die, and we both knew that what was going to happen. We just kind of pretended that we were waiting for an operation. I was 23 when my mum died. And according to the cancer register, she had lung cancer and skin cancer. She may well have had skin cancer, but they need to get their records put right. Because I spent weeks and weeks in the hospital with her having radium treatment for a brain tumour and there was no record of it. So, there's no way knowing whether my mum had had breast cancer. She had so much cancer..... And my sister had breast cancer, but it wasn't breast cancer that killed her. It (the cancer) must have been about 26 years ago. At the time, there wasn't the surgery available, you know, the reconstruction..... it was so brutal. Then she had emphysema. And she was in hospital last year with pneumonia and she got sepsis. So, it was the sepsis that actually..... I never cry. You're making me cry. I cry more about my sister. Because that was very sad. How she died was sad. She always felt as if she was going to die with the breast cancer. She suffered terribly with the appearance of her body. She died in 2015. She refused any treatment at all for the sepsis. She must have thought, "I've had enough".'*

Deaths from Other Illnesses and Accidents

Majority of patients (7/10) mentioned also 11 deaths from other illnesses and accidents. 'A' and her husband had a very recent loss, during the interview process and they were going to a funeral next day. 'A's husband lost his brother who *'had just turned fifty and he'd always had cerebral palsy in a bad way.'* And 'C' had recently had her late mother very much in her mind, linked with her own mortality, as she herself was the same age now as her mother was when she had died. *'She died of a stroke, but she'd been type 2 diabetic for about fifteen years.'* 'D' talked about her son who had died accidentally. *'My son was diagnosed (with mental problems) when he was eighteen and he died when he was 33.... so, it was accidental death.'* And 'J' had lost her mother and mother-in-law not long ago. She told me how she had decided to retire when she was 60, because her mother died and four weeks later her husband's mother died. *'So, we just seemed to go from one awful situation to the next awful situation.'*

Stillborn Babies

'C', 'D' and 'L' talked about their stillborn babies and there was a feeling as if the losses had almost happened yesterday. Some patients also had a few vague memories of their mothers' miscarriages although these incidents had happened so many years ago. 'C' tried to tell me about her own experience in a very matter-of-fact way. *'And I had a still birth, many years ago. I carried him nearly full-term. And it was an encephalic, which is like spina bifida, but it affects the brain... I never saw him. I never heard him cry. My husband took the certificate to the undertakers, and they said they would pick the baby up from the hospital and they would put it in the bottom of a grave.... and then somebody would be buried over the top of him. In my head, at the time, it wasn't really a baby. It was a lump that I had to get rid of, like a breast cancer that I had to get rid of now. Although I did sometimes wonder, at the time, was it that horrible? Was it that deformed?'*

Powerful emotions took over 'D' when she was sharing her own experience with me. *'I had a stillborn baby, yes. That was terrible (suddenly bursting into crying). They took your baby away and you never saw the baby. The only thing that one of the nurses said to me, was that "it was a little boy". She said, "it would have been much worse if it had been a little girl". You see, because I already had three boys. And that was it.'* The stillbirth was a very powerful experience also for 'L'. *'I lost a little boy in 2011. That was a stillbirth. I had a breakdown after losing him. I was like, "I can't do this anymore", so that was it.'*

4.3.5.4. Loss of Identities

If the breasts had been an important part of a woman's identity, then losing a breast may be felt as if a part of one's identity was lost or being at risk (Appendix no 23: Loss of Identities).

Loss of Feminine Identity

Only 'L' who in her late 40's, was the youngest in the group, was seriously concerned about the danger of losing her feminine identity. However, 'L' was more at risk than the others because of her particular psychological vulnerabilities. Her acceptable, good identity as a woman had been very much based on her physical looks and the fear of losing those made her very vulnerable. For 'L' her breasts had been the part people liked in her and losing her breast would have meant to her becoming a lesbian cancer victim. *'People, I guess, liked my breasts. Probably for the first time, there was a part of me that people liked.... So, to just throw out, "oh, we will just go and operate and do a simple mastectomy"..... I was like, "I can't deal with this". You are losing your hair, you are losing your breast, you are losing everything that... makes you a woman and, you know, it's hard. I don't want to look like a cancer victim and I don't want to look different..... What I wanted to do, in 2017, was to renew my wedding vows. And obviously then, the breast cancer op, and now we've got no hair, everything's been delayed. I can't go and do that when I look like this. I look like a dyke... I do look like a lesbian.'*

Loss of Matriarchal Identity

Particularly 'C', 'D' and 'M' (3/10) who had had a role identity of being very much the 'driving forces' or matriarchs in their large extended families, were worried because their central position to keep daily routines going, were now at risk. However, even though this situation caused worries, it also created a few constructive changes in 'C's family where there was a positive shift in the dynamics as the other family members learnt to take more responsibilities. That gave 'C' consequently more space for her own needs. *'I was worried that I couldn't cope with the things I need to cope with, to keep the family ticking over properly. Things like babysitting, stuff like that, you know..... that things wouldn't get done, that should have been done. I didn't want to tell my dad because I do my dad's shopping on a Saturday. I just don't know what I'm going to do if I get radiotherapy and I can't go and do his shopping. I've always been the one that was doing everything for everybody else. I'm down to three days a week now at work because I can't cope with my dad on a Saturday, and babysitting my daughter's kids, and everybody comes to my house for Sunday lunch, and working five days a week. I just don't have the energy; I can't cope any more. And I was talking to my sister. She said, "let them do it. Just let them sort it out for themselves". So, everybody in the family took a*

step back and looked, you know. There has been a very subtle change, like I say. My husband and my son and my older grandchildren are more attentive..... probably for a few years, they've been taking me just for granted.'

'D' found it challenging to let go some of her control and become dependent because in her childhood years she always had to be independent due to her mother's chronic illness. She explained to me how she just felt now so disconnected. *'I've always been in charge of everything, and now I'm in charge of nothing..... That's the first time I've ever asked them to do anything. That's the bit I don't like, me needing help. I like being independent. I've always been very involved in things that happen at Christmas and this year I've just had to step back knowing that I wouldn't be able to do things.'* It was also hard for 'M' to try to carry on in her old role where she had *'always been the strong one.'*

4.3.5.5. Loss of Relationships

For most patients (8/10) the loss of breast also brought into their mind psychological losses in terms of past relationships which were now broken. These lost relationships included those of husbands and other members in their immediate or extended family. Talking about these experiences did not take very much space in the interviews. They were mentioned in passing, mainly creating feelings of sadness, and probably also resentment when the patient herself would have needed some support at the time of her illness (Appendix no 23: Loss of Relationships). 'A' blamed her husband for not giving her enough support and she related this current situation to their difficult marital relationship that had been going on for some time. *'I do blame my husband. I blame him for our life going haywire in a split within the family. For losing my children in that stage, I blame him.'* 'D' was very sad that one of her sons living far away abroad did not want to be in touch. She explained that *'he just wanted to go away. I'm his mother, yes, and I suppose there will come a day when he's just too late.'* Also 'G' had painful losses because her sister, *'she never comes up, never does her share (in looking after their elderly mother). She's just not doing anything, which is not fair. And my oldest granddaughter. I haven't seen her for years.... the bond was sort of broken. Her mother died about nine months ago of brain tumour. It's very sad.'* And 'K' felt resentment towards her father who 'left her' when the parents divorced when she was about eleven. *'My father never sent a birthday card or bought a present or Christmas present.'*

4.3.5.6. Comments on Losses Endured

General Notions about Losses

Being faced with the reality of breast cancer and possibly losing one's breast (or parts of it) which is a vital visible part of being female and linked with one's bodily 'self' feeling, demands a lot of internal strength from any woman. Psychoanalytic theory gives understanding to why going through this process of loss may be easier for some women whereas others are left struggling. If the individual's internal world is based on secure early experiences and 'holding environment', then with the help of this internalised 'good enough' early environment she will be able to better manage and get gradually over her difficult present-day losses. The traumatic losses can be gradually accepted in a less conflicted way. This does not mean that the individual would not have difficult feelings after hearing the news. However, if the past struggles have been successfully come to terms with, the individual will be able to grieve her present losses and they will not become mixed up with the past ones.

On the other hand, if the infant's early environment has not been emotionally secure enough and she has not been helped by her parents to process her early losses and the later ones, these undigested experiences will become alive again in the present loss. As I have indicated earlier, in every person's life, as part of her normal separation-individuation process, there are fears such as loss of a loved person, loss of her love and loss of 'holding environment'. If these earlier more unconscious losses linked with various developmental stages have not been managed 'well enough', they create unmanageable problems in the future. In a case of a previous death, accepting and grieving the loss will be more problematic if there have been conflictual feelings. For example, aggressive feelings towards the lost person can lead the person left behind to feel responsible for the loss.

Losses in the Interviews

The presence of the past was very noticeable in the interviews. It was as if the loss of breast (or parts of it) had brought up all kinds of experiences of other losses into the patients' minds. The losses were either physical, as for example losing a person via death, or psychological, such as the loss of a relationship. Many of these losses became alive again evoking powerful emotions. This was an indication that the earlier losses which had happened typically many years ago, had not been fully worked through in the patients' minds. As I already indicated in the previous section (in relation to the husbands' losses), it seems likely that if the earlier losses have not been sufficiently emotionally grieved, they may have become separated and encapsulated in the person's mind, but then brought alive again as a result of a current loss.

It is very important to remind here that in the interviews I did not specifically ask about losses with the patients, but this topic came up spontaneously when the patients were free associating within the 'holding' structure of the interviews. Using the free association technique (which I have explained in a more detailed way in the 'Methodology' section) gave the patients a space to talk about whatever came to their minds. They were encouraged to move from one idea to another and thus reveal their unconscious interests in these matters, most probably provoked by their own present illness. A good example of this was 'K' who told me that she never cries but she said that I now made her cry. However, I don't think it was me who made her cry, but the free association technique loosened her emotions. In this way all her painful past experiences with her late sister and mother, which she had pushed away in her mind, became more alive and made her cry. 'G's earlier cancer experience, a loss of her womb, was lingering in her mind for many years. She had become severely depressed and was still on a mild form of antidepressants. I questioned whether she had ever been offered any 'talking therapy' in addition to her medication but just been left with her painful loss on her own. There were quite a few cancers around in 'G's extended family members at the time when she herself was diagnosed with breast cancer, and she found it difficult to have a space to think about her own present loss.

'M' had been closely involved with her twin sister's breast cancer treatment some years ago. And as I have mentioned earlier in the 'Having Treatments' section, her sister suffered a severe mental breakdown, a loss of her mind, which was in 'M's view linked with her sister's treatments. 'M's own present fear of treatments may have now been linked with her fears of losing also something else in her own mind, that is the control of her difficult feelings. 'M' was now displacing her own fears into her sister's breast cancer experience and her breakdown. By using this kind of defence, it was easier for 'M' now to manage her own anxieties even though her continuous nervous coughing was possibly a 'preconscious' sign in her body that there were threatening feelings around but cut off from her mind at the moment. And 'M' became very emotional when she was talking about her middle daughter's brain tumour many years ago. As a result of this trauma her daughter had lost some functioning in her hearing and learning capacities. Having to be strong for her young child must have made it difficult for 'M' to be in touch and work through her own painful feelings in those days.

Many patients talked about their experiences of previous deaths and again I did not ask especially about deaths but memories of them arose seemingly spontaneously in the patients' minds, often already during the first interviews. Many of these losses were related to various cancers. For some, it may have been easier to use a defence of displacement and talk about other people's deaths than facing their own mortality. However, towards the end of the treatments the patients were more able to reflect on their own mortality and I will come back to this topic later in the section about 'Long-Term Impact of Breast Cancer on the Patients' Life'.

In some situations, like in the case of 'B', 'K' and 'M', the reality of the other person's approaching death had never been talked about. 'B' had to carry a lot in her mind when her husband was dying and in her own belief, she was the only one who had been told about the palliative nature of his care. If these kinds of emotional issues, though very painful, had not been addressed between the spouses, whether there were also some other difficult subjects in the family that had been suppressed and not communicated. Probably, as a result of this 'non-communication', 'B's younger daughter had 'collapsed' after her father's death. She had not been able to recover from her breakdown and was now 'housebound' and being cared for by 'B'.

When 'K' was nursing her 'cancer riddled' mother at home till her death, her mother's approaching death had never been talked about but defended against by using denial. 'K' told me that neither her nor her mother acknowledged that painful reality, but instead both were pretending that they were waiting for an operation. Also, in 'M's family the issue of death was difficult to face, let alone to work through. 'M's father had died 'like a cancer patient' but she believed it was not a cancer. Her father had refused to have his lump operated and was terrified of cancer. He hated that word and probably in this way wanted to deny its reality. Also 'M' herself hated the word 'cancer' trying to distance herself from it. Later on, the cause of 'M's father's death was never talked about in the family and even to this day 'M' does not know the reason for his death. In this way facing the painful loss of him was denied by the whole family, probably by using wishful thinking that if it was not talked about, it did not exist. All these recollections made me think about how difficult it must be to lose real people, one's loved caring objects if it also means a threat for the person that she can't find internal strengths to manage and work through those losses.

'A' had a very vivid picture of herself as a young schoolgirl visiting her dying grandmother and trying to take her mind somewhere else by looking at the wall. She thought that this experience had had a powerful effect on her life and had created a 'phobia' of throat cancer. As I have explained previously, a frightening idea which is linked with a distressing or disturbing experience, will sometimes be withdrawn from a person's consciousness and replaced by a phobia of something else. So, whether it was not only the experience of seeing her dying grandmother but probably also some other more unconscious earlier issues in 'A's life which were represented in her throat cancer phobia. There is a question whether 'A' was ever helped sufficiently by her parents to process her feelings after her disturbing experience with her beloved grandmother. A more 'holding environment' would have helped 'A' to process her frightening feelings instead of having to attach them to the phobia of cancer in order to protect herself against them. In 'F's family there had been many painful losses of close family members from cancers; her healthy sporty brother and father both died four months apart and later on she lost her ex-husband. However, there was a feeling that 'F' had had internal strengths to go through these losses and she talked about them in a more composed way.

One option to defend against painful feelings is to detach oneself from them. Some patients, such as 'C' for example, who had had previous cancer alerts when she was frightened of dying, and 'J' who had gone through a very difficult cancer experience forty years ago as a young woman, both tried to talk about their memories in a very factual way. 'J's experience must have been very painful because, as a result of her chemotherapy treatment, she had lost her fertility. She claimed she was never informed at the time that there would be these consequences. And she was unaware of the length of her stay at the hospital and of other procedures she was going to have. These experiences must have been so overwhelming for a young woman in her late teens that 'J' needed to cut herself from her frightening feelings. In order to protect herself against them she developed a tendency to faint when even minor medical procedures were administered to her. However, to manage her disappointment of not being able to have her own children, 'J' had enjoyed her working life amongst children as a successful sublimation.

If the losses had not been emotionally dealt with previously, now the current loss functioned like a trigger to the patients, bringing back to the surface previous bereavements, many of them having happened a very long time ago but had been suppressed all these years. Quite suddenly these past incidents became very much alive in the present, provoking difficult emotions. A good example of this was 'D' who told me in the interview about her stillborn baby and suddenly burst into tears. There was a feeling as if this loss had almost happened yesterday.

The loss of one's self-image in relation to sexual body may be more threatening for younger women who have physically more to lose, such as their fertility, as for example in 'J's case. However, 'L' who in her late 40's was the youngest of the group, was seriously concerned about the danger of losing her breast and she even had suicidal thoughts as a consequence. The breasts had always been very 'valuable' for 'L' as she believed that they were the only body parts people liked in her. Here I am reminded of Lipowski's (1981) notions that the greater the subjective value the diseased body part has for the patient, the more intense her psychological reaction is likely to be. However, 'L' was also more at risk than the others because of her certain psychological vulnerabilities. Her acceptable, good identity as a woman had been very much based specifically on her physical looks and the fear of losing those made her feel very exposed. Nevertheless, 'L' felt happy towards the end of her treatments because she was going to get her new 'designer boobies' in the breast reconstruction operation. In the case of some women, like 'C', 'D' and 'M', the loss of their role as the matriarchs or 'driving forces' in their large extended families, was clearly threatened because losing their identity would have meant losing their control and exposing some vulnerabilities in themselves. Nevertheless, 'C' was able to see also some positive changes from this loss as it allowed her more time to look after her own needs.

I will return later to the concept of losses, the other major finding in my study, in the 'Discussion of Results' section in order to understand it further from a more theoretical point of view.

4.3.6. Long-Term Impact of Breast Cancer

It is not surprising to find that the topic of cancer was unfinished 'business' for most of these patients even though all the treatments, except the endocrine therapy, had been already completed by the fourth interview. The cancer was still a shadow in most women's life. It was a reminder either in the form of debilitating physical aftermaths, such as various pains and tiredness, or in the form of lurking not far away from the women's minds. It was often causing feelings of being left to their own devices and fears of their cancer returning.

4.3.6.1. Impact on Body

Many patients (7/10) described that their bodies had somehow changed. It was not their familiar body of the past but, in some ways, a different one now; less able and physically more restricted (Appendix no 24: Impact on Body).

Changed Body

'B' said that her 'old' body had gone, and she needed to learn how to cope with her 'new' one. And she went on, *'I'm restricted. Yes. I'm not fully fit to be able to do what I did.... I'm left with a skewed body that is tired and out of alignment. The body will have to get used to a new physiology. It's learning again. I feel asymmetric.'* Also 'D', the oldest of the patients, had noticed the change as she seemed to have turned *'into an old lady overnight.... and I haven't got time to be an old lady. And then suddenly people are standing up for me in the bus and the bus drivers are saying, "how are you getting on".'*

And 'K' was worried whether she will ever get back her old levels of activity, saying, *'I've been told to be careful.... not to do anything too strenuous, not to carry anything too heavy. So, I find that's life changing because I've never been a person to stop. I would like to dig a pond and dig a bush out and carry heavy things, you know. And it does worry me that life might never fully get back to the way it was.'* Also 'M' was regretting the loss of her activity. She found this very hard because she had always been very active but now *'walking, even to walk down that shop, would kill us.'*

Aches and Pains

Many patients (7/10) were still suffering from different kinds of pains which created uncertainties in their minds. 'A's occasional pains alerted her fears straight away that something more was going on. *'I get a few pains now and again and your mind automatically jumps to, "oh, is it coming back"..... Because you don't know what those pains are. Your mind still can't help wonder, is this pain all right..... purely, because I didn't have any symptoms or signs originally.'* 'B' was still in a lot of agony because she had pain down her arm and down her side. *'And it's the whole body. It's still not solved. It's still there. Until this nerve pain is sorted, I will always feel lopsided.'*

Also 'G' suffered from different kinds of pains restricting her mobility and disturbing her sleep. She told me that *'I got a lot of joint pain with the medication and could not walk far. My back was hurting, my joints were hurting, and I had breast pain. I was really feeling sorry for myself and I was close to having a mini breakdown. I got pain in the back of my ankles, which I think is tendonitis. I must go to the doctors and get it seen to. I can hardly walk up the stairs sometimes..... Maybe within an hour I just wake up. I then feel as if I am restless and my legs are restless. I am tossing and turning and then I have to get up because I am just disturbing my husband.'*

The pains made 'K' suspicious about their origin and she was telling me that *'I'm just aching. I find that in my hip and my thigh. I hope it is the tablets. And I'm getting some splitting piercing headaches but this pain is like in a specific area and I sometimes think, you know..... Why they don't check your whole body, but I suppose it's the cost, isn't it? They'd rather wait and see if something else goes wrong, rather than see if something else has gone wrong.'* And 'M' was still in a lot of agony disrupting also her sleep. She described that *'it's like being hit with a truck. Every ache in your body, every step you take, horrendous..... I just have to pull myself on the bed and find a comfortable position. It is just, basically, cushions filled up...I'm not sleeping like I used to do.'*

Feeling Tired

Half of the patients found it difficult to cope with their tiredness which they had not suffered from before. 'D' for example did not expect this kind of fatigue as she had always been very active and she *'just didn't expect this aftermath.'* And 'G' had understood that she needs to listen to her own body. She explained to me that *'they said I won't be myself for a few more weeks. I am going to feel tired and I do. I am absolutely exhausted now but I have been walking round the shops as well. They said, "when you are tired, rest. Do what your body is telling you to do".'* 'K' was lacking energy, saying that *'some days, I would be happy to not even get washed and ready, to be honest with you.'*

Anger Towards One's Body

'F' was able to express some anger towards her body because she had always tried to look after it and now it had let her down. *'Yes, that's how I feel like.... "how dare you". I mean, I have always tried to look after myself. I have always had a good diet. I don't smoke. And I might have the odd social drink, but I haven't had a drink for a long, long time. I have always kept myself reasonably fit..... and you suddenly think, "why did that happen, how did that happen". It's like, "how dare you to do that to me". I am not annoyed with anybody else... but you know, people smoke and don't eat well, and they are overweight.'*

'K' had experienced many problems with one breast, but it was her other breast, the 'good' breast, which she had thought was healthy, that had 'betrayed' her. She explained to me how *'in this breast I have so many symptoms. I can't believe that it's not this side. I've had fine needle biopsies; I've had a proper core biopsy. But this breast is clear from cancer, even though it causes so many problems. I'm furious. I'm really annoyed with myself, why did I just become so complacent after having a mammogram every year and having so many problems.... it's too late, now.'*

Still Problems with the Operated Breast

The operated breast remained a concern for some patients (3/10). 'A' became easily doubtful about her lumps explaining to me that when she was first diagnosed, she felt no lumps. But *'now when I've had the operation, I've got loads of lumps. So, I'm thinking, which ones are the bad ones and which ones are the good ones.'* 'K' was disappointed with her implant because it was causing her problems. She was always conscious because *'you know, it feels like an implant.... It's hot and it's sore. I suppose at the moment something's not quite right with it and I'm obviously a bit worried as to what's wrong with it.'*

More Positive Outcomes

'L' had been very angry and upset before her surgery because she was given an alternative recommendation by another doctor about what surgical procedure she should have. Nevertheless, the original operation plan went ahead, and she had a skin sparing mastectomy. She then had an implant which did not feel so good. However, she was very happy with the way of how it looked. *'That's what I wanted, the implant. And when you're in your clothes, you look normal.... but I know it's not. I know if I feel it, it doesn't feel great. It's so hard, and when you touch it, you can feel the fluid moving around. It's a bit weird but it looks more normal..... I don't feel so much a bereavement for losing my breast because I feel there's something there now. If that hadn't been there, I think I*

really would have been badly affected. I really wouldn't have coped with it not being there. They've healed amazingly, and all of the breast care nurses have said, "what a good job they've done". I was like, "oh, well, I'm dead pleased". With eight separate lumps that's an awful lot in one breast. There wasn't really a hope, was there? I think I've been lucky to keep the skin, so that the implant could sit in the skin and look normal..... As I say, fantastic results of the surgery. The lady who did the bra fitting, she was like, "oh my God, they're lovely, aren't they" and I was like, "I never thought anyone would say that about my breasts". She said, "that's really, really good job". And I said to them, "I'm getting my designer boobies".'

Some patients were focusing upon health instead of illness. They were trying to lose weight in order to find new ways now to make their bodies healthier and, in their own way, to try themselves to help to reduce the risk of recurrence. 'L' acknowledged her problem of comfort eating but wanted to end that tendency and see the benefits of it. She thought that her weight loss could then help to prevent the recurrence of cancer. She explained to me that *'I've gained a new kind of skill, if you like. I've lost about a stone and a half since. So maybe I'll come out of this with being able to challenge my relationship with food, which can't be a bad thing. So, losing weight will help me feel better and it will help to stop the cancer returning. There's an impact on cancer returning and obviously, as I say, what's the point in going through all of this if I don't do my bit as well.'*

4.3.6.2. Impact on Mind

Being Left with Different Worries

All ten women expressed how their cancer experiences had had a long-term distressful impact on their minds (Appendix no 25: Impact on Mind). 'J' recognised how she had been frightened at the beginning of her 'journey' even though she had not been in touch with those feelings in that time. She told me how a friend of hers had bought her a little book and *'it's quite interesting to look back to day one and see how things have gone and how I feel. I am less frightened now than I was then, when I read what I wrote then. I read, between the lines, that I was quite frightened.'*

The whole cancer experience was still very difficult for 'C' to believe because she felt great all the way through. *'I had no symptoms. I felt absolutely fantastic. I had no lumps, no puckering that they tell you to look out for.'* There was still disbelief also in 'A's' mind and she was convinced that she would have never been able to feel the lump *'because it was deep inside the breast. So, it wasn't something I was going to feel eventually. Little sly, nasty bugger. It never showed itself, but it was there. I never had any symptoms. There were no lumps. Nothing.'* And 'D' who was so used to be in control of everything, was in a shock that something had been out of her control without her knowing

it. *'It's not that I'm bossy, I just know everything..... but that was shocking that I didn't know that I had breast cancer..... that I could be vulnerable. I was shocked.'*

Fears of Being Left on One's Own

Many patients (7/10) feared that they would be left to their own devices, almost 'abandoned', when all the treatments, except the endocrine therapy, had been completed. 'A' had a wish that the staff members would never let her go. And she told me, *'I said, "I don't want you to let us go because how can I trust my own body, and how can I trust me if I didn't feel it in the first place". So yeah, if I had my own way, they would never let us go. I would keep coming forever because I'd be frightened, in case it started up again without me knowing. I don't want to go yearly to mammogram. Give it to us every six months.'*

'G' had a phantasy that the staff members had become her little 'hospital family'. She recollected that when she finished her last appointment with Mr X, she had *'a weird feeling. I didn't have anybody to come and see. I was like having withdrawal symptoms because they were so caring here.... and all of a sudden, it all just stopped. It's like I had lost my little family at the hospital. It was weird. They became like a family to me. That's how I felt.'*

Fears of Cancer Returning

Half of the patients (5/10) talked openly about their fears and anxieties about their cancer returning. 'A' thought that she will always worry that her cancer will come back. *'That scares me, to think that "how do you trust feeling yourself" if my cancer was not going to be detected other than through mammogram. They'll say, "you've got to be breast aware" which I was always anyway because of my mam and because of the history of the cancer in the family. But even then, I didn't detect it. Can you ever say, you're a cancer survivor? Because cancer's a tricky little bugger. And it's a little clever bugger at the same time. So, I don't think you can ever say, "I'm cured or, I've beat it". Because you get that slight negative inkling that remains there. I think I'll always live in fear of it coming back. I still worry.... that it's going to come back because I didn't have any symptoms in the beginning, and I thought everything was all right. So, if I don't have any symptoms now, how do I know in the future that it's not starting again somewhere in there.'*

'G's mind was also overwhelmed by similar kinds of fears when she shared with me that this question *'always plays on your mind as well, "will it come back". For years after I had the cancer of womb, it was always in the back of mind, "what if it has gone somewhere else". My brain just wouldn't*

let me go to sleep and that is why they put me on these tablets just to relax me. If I forget to take one, I will have a bad night.'

Also 'K' was worried, like her late sister, that whether her cancer will come back or whether it was already somewhere else in her body. *'And I know it can travel through your lymph nodes and your blood, so I don't know. They took two lymph nodes, I think. But then you hear that they've taken, like, seventeen out of some people and five of them were.... "my Goodness". What if they'd taken more from me and might have found something. You can't help it, it's just a natural reaction. My sister was always convinced that she had cancer somewhere else in her body.'*

'L' had quite pessimistic ideas about her future, telling me that she had done recent 'research' again *'and it kind of said that no-one survives breast cancer more than twenty years. Within that twenty years it will have come back in one form or another and you will have died. If it was to come back in the other breast..... but what if it comes back elsewhere? What if it came back in the lungs or the liver? There is no remission for breast cancer.... you're cancer free until you find a lump. So, there's not that same peace of mind that you get with other cancers..... I need to reduce my risk of cancer because, obviously, my risk of cancer now is increased. And it was such an aggressive cancer that I have to have that in my mind as well..... It's always in my mind. I think what's disturbing is that they can't tell whether or not you're cured. With breast cancer, they never know. You only know when you find another lump.'*

Future

Many patients (7/10) talked about death. When some patients (4/10) were talking about their future, they would see that their scare of cancer was always going to be present somewhere in the background of their minds. 'A' thought that she could never trust again in the future because *'you tend to live with a little cloud following you. I'll always be looking over my shoulder in that sense, as regards to the cancer. I don't think I could ever leave it behind. But there's nobody who can turn around and say, "well, you're cured. Get on with the rest of your life now". But that little thing on my shoulder..... it's always like, "don't forget about it too much". It happened once. Is it going to happen again?'*

Also 'K' found it difficult to trust in her future, ever again. And she told me that her husband is a bit of a saver. *'And I keep saying to him, "what are you saving for". And he'll say, "when we retire". And I say, "we might never retire". You know, nobody knows. Absolutely nobody knows the future. Now I think, "oh my God", I'm only 61 and I cannot really enjoy the life as much as I've always said before because I feel hampered. I've thought I'd love to be at home and be retired, but not to be like I am*

now, you know. I've got to find a "new normal" now because I think the "old normal" has gone... but I worry about everything and everyone.'

Realisation of One's Mortality

The idea of death was in the minds of many patients. When 'L' spoke about her fears of cancer returning, she also mentioned dying. *'The other thing is, I mean, my hubby gets quite annoyed with me, when I want to go and organise my funeral.'* And 'M' found it difficult to trust that her future will ever get better. The death was in her mind too when she said that *'I might as well pick the things that I like and get my funeral arranged, that was where my mind was going.... Oh, it's never going to get any better.'*

For some patients the realisation that the phantasy of 'life being eternal' is not sensible, meant that they were able to appreciate and enjoy more their life here and now. 'C' had an important insight when she told me that *'there's another thing the cancer scare does for you. Because I thought, "you know, why bother? How many years have I got left? I could well live until I'm 80, but am I going to be like my demented dad in ten years' time". If one can find anything positive, it's the realisation, "look, you have a limited time".'* Also 'F' saw how vulnerable our life can be and she stated that *'it does make you more grounded, because you realise how fragile life is and how easily life can just change. Never take anything for granted.'*

'J' took quite a rational and pragmatic approach to her mortality. *'I've had a will for years and every now and then I update it. So, I said I'll update my will just to make sure everything is absolutely watertight. It makes you think about your own mortality, yes. We went for a walk a few weeks ago and it always takes us past the cemetery.... So, I was going along saying, "for my headstone, I want a headstone like that, and I want a wicker coffin"..... We made a bit of a joke about it, but it does make you think about getting things organised. It makes you aware that you're not going to go on forever. That there has to be a start, a middle bit and an end. I'm not afraid of being dead. I'm worried about the route, the pain. I'm afraid of pain.'*

Being Lucky

Nevertheless, in hindsight, almost all patients (9/10) regarded themselves as being lucky, after all, because their cancer had been detected at an early stage by the mammogram. For most patients, there was no way, that they could have picked up any symptoms of their illness by themselves. In many respects, 'A' regarded herself lucky, but she was hoping that she could hang on more to that feeling. *'I feel extremely lucky. I do. But I wish I could harness that feeling "extremely lucky" a bit*

better in my attitude and outlook. I sort of thank my lucky stars that I haven't been told at this stage that it's terminal.' Also 'C' felt lucky, especially, when she had missed her previous checks. 'F' thought that in some respects, she felt lucky because *'they've caught it before it's advanced. It's contained now.'* And 'J' again took a more practical view saying that *'if you had to have cancer, this is the best one to have.'* 'K' stated that she had been *'unlucky to get breast cancer, but lucky with the outcome. So, I've been unlucky but lucky.'* Towards the end of her treatment also 'L' was able to find some positive issues, regarding herself *'very lucky as it's so aggressive..... and to actually find it, while it's still contained. The prognosis is quite good. They go, "oh, but you're always smiling". And I'm thinking, "well, because I've still got hope".'* And 'M' was able to see some positives telling me how she said to her 'youngest' that *'well, I'm luckier than some.... because some don't get to see their children.'*

'D' regarded herself as being very lucky when she had been referred to this hospital from another hospital where she had not felt safe. She had also found her faith helpful when managing her situation, saying that *'whatever happens to you, is what God has planned to you. Even if you sat there and said to me, "well, you've only got three months to live". I'd think, "hmm, right then... that'll be it"..... Every now and then I change my hymns. I hear another nice hymn, so I say, "I'm having that one". I've got my picture chosen for the front cover as well. It has no fear for me. I'm going on to something better.'*

Empathy and Understanding Towards the Others

Half of the patients (5/10) felt that, through their own experiences, they now had more empathy and understanding for the sufferings of their relatives. 'A' had her grandmother in her mind and she was now also able to appreciate the help that was given to herself. *'They're doing the best for you on all levels and, like my grandmother.....and people that have just passed away this year through cancer, they all would have wanted to be the ones that were told "we can cure you".'* And 'F' had been thinking about her own mother saying that *'I often think of how my mum must have felt.... to have lost.... her husband first and then, four months later her eldest son. I am lucky because mine was caught at the right time before it had spread..... comparing myself to my dad, my brother, my husband and my cousin. Seeing all that, I don't think I've been through anything near what they've gone through.'*

'K' was now more able to understand her older sister's sufferings, stating that she did not realise what the breast cancer must have done to her sister *'even though you're sympathetic because she was my sister and I loved her. Now that you're in the same boat.... you don't realise what she had gone through until..... I'm going to get upset now.'* And 'M' could now put herself even more in her

young daughter's position when she had her treatments for the brain tumour. *'My daughter had radiotherapy for hers and then she was ill a while after it and bless her. I said to her the other week or month, I said, "God, if you went through any of this as a kid, I'm sorry". Nobody knows what this is like until you actually go through it yourself.'*

Positive Developments

A few patients were also able to make some positive developments out of their distressful experiences. A good example of this was 'C' who decided to retire earlier and find more time for herself. She explained to me how she had always said that she would work until she was 65. *'And then having had that cancer scare, I thought, "well, why? I don't need to, really". To be honest, I keep thinking, "maybe I should just give my work up altogether". I'm going to retire next year, I've decided. But I'll not be doing nothing. I've got a lovely doll's house to decorate, that I haven't even got started on.'*

'F' told me that the cancer experience had given her new strengths and she decided to do some voluntary work for other cancer patients. *'I've been through this and I think if you can do this on your own, it makes you appreciate what you have got in your life. I've come out of it and I feel, at this moment, a lot stronger. I feel quite proud of myself, how I've handled it. I did a voluntary thing at X on Monday... I might just do it again once a month or twice a month. I have done voluntary work before, I worked at the hospice.'* And 'G' decided to encourage breast awareness amongst other women, saying that *'you don't think it's going to happen to you. So, I tell my daughters now, and tell their daughters, to check themselves regularly. I say that to anybody now.'*

4.3.6.3. Comments on Long-Term Impact

Body

Some aspects of our bodies are always visible to other people. Our bodies, in Solms' (1995) words, could be seen as reflecting the infant's earliest bond to her mother. In adulthood we are functioning more like mothers towards our bodies, often repeating more unconsciously our infantile experiences. However, this 'looking after' one's body had not gone so well in the context of these patients' cancer and its treatments. Some patients feared that their bodies, which had gone through a lot of pain during the treatment process, were now going to be visible as some kind of 'cancer victims' by others. Here I was reminded by Wright's (1991) description of the 'other's view'; not mother's loving look at her baby but the 'other's critical cold look' coming from a distance at somebody who is now seen as a kind of pitiful spectacle. In this kind of situation, the person sees her own 'self' through the eyes

and looks of others. This was very much a concern for 'L' for whom her looks had always been very important. She even needed to postpone her plan to renew her wedding vows because of her worry that people around her would see her looking weird. These obviously were 'L's own thoughts about her looks which she now had projected into others seeing them as critical as she was herself.

The loss of the body as it was before, caused sadness for many patients and this loss needs to be grieved over time so that the person affected can move on in her life. Many women realised that their own familiar bodies had been altered. And there were concerns that life in general with the changed body was also going to be changed and become different for ever. These thoughts created fears for the future. 'B' for example had to get used to her new 'physiology' and 'K' had to find her 'new normal' when her 'old normal' had gone. 'K' had lost her previous activity levels and 'D', the oldest of the patients, experienced that she had turned into an 'old lady' overnight. The tired body was making life feel like a constant battle also for 'G' and 'M' who felt that their mobility was now restricted.

Many patients had various kinds of aches and pains in their bodies. This reminded me of the notion (Kaplan-Solms & Solms, 2000) that our body with its demands, in this case the body sending messages of being in pain, is disturbing our need for peacefulness. We will recognise that the body is not under our omnipotent control anymore. This realisation is very powerful in a situation where the individual has been suffering from a serious physical illness. Some patients, such as 'G' and 'K', linked their pains with their endocrine treatment but there were also worries that these pains were signs of the cancer coming back. This was a concern that 'A's mind automatically went to and 'K's ongoing alarm was that the medical staff had not checked her whole body carefully enough for cancer cells. Here 'K' was identified with her late older sister who, after having had breast cancer, suffered these kinds of fears for the rest of her life. Both 'B's and 'M's bodies were still in constant agony. Troubles in the operated breast raised uncertainties and fears in some patients as they were unaware of the cause of the problems. 'A' became suspicious of her lumps and 'K' was disappointed with her implant. A few patients admitted that they had experienced anger towards their bodies because they felt that their bodies had betrayed them; as if the body had disintegrated and almost developed its own 'brain'. 'F' for example had tried to look after herself physically in many ways and was left feeling angry because her body had 'dared' to do this to her. 'K' who had always had problems with one breast, realised that it was the other breast, her 'good' breast, which had betrayed her. The physical illness had diminished their bodily 'self' image. Borrowing here the words by Winnicott (1988) whom I have referred to in the earlier sections, the person's 'self', the feeling who she is, is, in health, normally experienced in her body. However, now the body was felt as being independent of the mind and it seemed to have developed a life of its own. And in the patients' mind the body had not bothered to inform them that something was seriously wrong.

Mind

A physical illness as an external danger situation can threaten to fragment our coherent integrated body sense (Solms, 1995) and if the individual's internal structures are not very solid, this kind of danger will create distress associated with narcissistic traumas, often with early losses. All women pointed out how their breast cancer experience had psychologically impacted on their minds. It probably was a bit easier for some of them to voice their worries and reflect on their experiences more openly now, once they were some safe distance from the earlier stages of their illness process and the physical situation had calmed down to some extent. Their usual defence mechanisms were now managing the situation much better. 'J' for example, who had cut off her feelings and taken a very practical outlook towards her illness, had written down her thoughts during earlier stages of her illness. It was interesting to see how now when she was reading her old notes, she realised, 'between the lines', that she had actually been quite anxious then but unable to be in contact with her emotions.

Living through the cancer experience had been very powerful and overwhelming for most patients. The diagnostic phase at the beginning had created the highest anxieties because of the fears of the unknown. Most of the patients had not had any physical symptoms and they had no idea that something threatening was going on in their bodies. 'A' and 'C' were still somewhat in denial, finding it difficult to believe that their cancer experience was 'real' because they did not have any symptoms and there was no way that they could have been able to find the tumours by themselves. 'D' had always relied on her omnipotent thinking that she knew everything and was in control of everything. She had always managed to defend against her needy parts, the opposite of her 'grandiosity', by displacing them into other people. So, now it was shocking for her to realise that she was vulnerable because she did not know that she had breast cancer.

After the treatments were finished, the women had to manage their struggles by themselves, without health service staff support. Some felt left totally on their own, especially, if there was not enough support at home. This was the case especially with 'B' who was very angry because she saw herself being 'abandoned' by her 'holding environment'; the outpatient and social services. She was left to her own resources to care for her incapacitated adult daughter. When 'B' felt furious at being 'abandoned' by the services, some of this fury was a displacement from her more unconscious anger at her husband's dying. His death had left 'B' in an angry state of failed dependency from which she found it difficult to move on. And 'A' felt being deserted without any caring objects around her because she felt that almost all her family members had turned their backs against her. I questioned whether in this kind of situation, the Breast Unit and the staff members there had been acting as a 'holding maternal environment' for the patients who got to know many professionals there. The staff

group was like a 'good-enough mother' who contained her child's different needs and unbearable feelings. In this way Winnicott's concept of 'holding mother' (1960 & 1988) was extrapolated to the outside world. Similarly, Rey (Quinodoz et al., 2001) referred to hospital as the 'brick mother' seeing the hospital's importance as a place of safety which offered continuity and stability for patients who were struggling. A good example of this was 'G' who felt that she had now lost her 'little hospital family'. This 'abandonment' was probably also reminding 'G' of her difficult childhood experience when she 'lost' her own family after being sent to a foster family for a period of time. Also 'A' had fears of separation and if she had had her own way, the staff members would have never let her go. When the patients were in this kind of 'childlike' regressed state, they were looking for omnipotent parents and perfect environment without any disappointments. There may have been also a phantasy in these women's minds that as long as they continued to be patients in the Breast Unit, they were safe and protected against recurrence of their illness. Probably some of the female staff members might also have had sometimes similar kinds of phantasies about themselves being protected. This kind of wishful thinking is of course a denial of reality as the Breast Unit cannot protect women against having breast cancer even though it can provide an excellent care.

The fears of cancer returning was openly talked about. 'A', 'G', 'K' and 'L' for example were concerned that there was no guarantee that the cancer would not come back, and one can never be confident that it had been cured (as if that was a guarantee which they should have had). I questioned how much this wish to have a guarantee of a 'total' cure, was also almost like a denial of one's own mortality and the search for eternal life. In some patients' minds the cancer had taken human qualities, 'A' calling it a 'little, sly, nasty, clever bugger'. And now, being 'abandoned' by the 'holding' environment, the Breast Unit, the women were left, in their minds, totally at the mercy of this bugger. The problem remained, as 'A' expressed it, 'how one could know that something was wrong if one did not have any symptoms in the first place'. This kind of situation of 'not knowing' left half of the patients in a frightening uncertainty.

'D', 'L' and 'M' touched on their own mortality by talking about their funeral arrangements. There was suddenly a realisation in these three that life does not last forever. The patients felt that their minds were taken over by cancer and the experience of their illness had robbed from them their trust that life would continue safely. 'A' and 'K' for example were never again able to trust in the future. Here I found myself thinking about a young child who one day, when she is getting older, will realise that she has lost her trust in her omnipotent idea that her parents will be always there and alive, keeping her safe and protected from dangers. The reality of experiencing a potentially life-threatening illness, so abruptly, was helping the patients to come to terms with their own mortality and to accept the limits of their own lifespan. 'C' for example realised that her life was here and now because everyone has got a limited time. Towards the end of the treatments and throughout their own experiences,

some patients were able to find more internal strengths that helped them to feel also empathy towards others. For 'A', 'F', 'K' and 'M' it was now somewhat easier to put themselves into other family members' situation and identify with them. That helped them to realise and relive with more compassion what others might have gone through in the past.

In this major section of 'Results' I have looked at the whole illness process and what kind of issues its different stages have provoked in the patients' minds. I have treated here the patients as a group. I will end the 'Results' section in the following part by giving short case summaries about individual patients and how each of them managed in their own ways their illness of breast cancer.

4.4. Summaries of Individual Patients' Cases

4.4.1. Interaction of Case Material and Theory

The purpose of these short case summaries is to give a general overall picture of the individual patients: how they managed the process of their illness and its treatments and what kind of other issues the breast cancer evoked in their minds. All the information I am now going to present in these short summaries is not new information but based on the interview material which I have presented in the categories in the previous chapters of this 'Results' section.

In order to form a 'whole' picture of each patient for these case summaries I needed to have knowledge from two different sources. Firstly, in the interviews with the patients, I needed my 'know-what' knowledge (facts), that is my explicit knowledge of the human mind and its development. This knowledge I had achieved through my professional psychoanalytic training and practice. Secondly, and most importantly, when interviewing these patients, I also needed my 'know-how' practical skills as an analyst. This implicit knowledge helped me to know how to relate to these patients and listen to their unconscious. I was using my empathy and tact to enable these patients to talk about their distressing situations. This kind of tacit knowledge I had built up over three decades of working as a psychoanalyst. During those years I had gained much experience and developed my skills. Implicit knowledge, which Kvale (2007) referred to as 'craftmanship', is a kind of expert work where the person does not focus on the method but on the task. Here, Kvale brings up the special technique of listening and refers to Heidegger who pointed out that it is not the hammer that the carpenter is focusing on, but the table he is going to build. These kinds of embodied personal skills which cannot be learnt from the books or be adequately articulated by verbal means from one person to another, unlike explicit knowledge, are acquired through experience. My sense of being in the same room with the patient was a part in my implicit knowledge of her; the patient's way of talking, her non-

verbal communication and the whole atmosphere. This helped my intuition to know, in this situation, how much the patient was able to talk about difficult issues in her life and reflect on them. This subsidiary awareness, in Polanyi's (1966) words, helped me to accumulate my knowledge during the four interviews and form a focal awareness of the patient.

It was important to have four interviews with each patient to provide a framework of continuity and safety in which the patients could bring up more and more difficult issues to the interviews. Their experience, that someone professional was interested in listening to their thoughts, probably meant a lot in a situation where all of them felt lonely and anxious. I want to emphasise that the goal of these interviews was different from the consulting room setting where the patient is having a long-term psychoanalytic treatment and testing the validity of hypotheses is possible because of the amount of time available for the treatment. Thus, the aim, technique and frame of interviewing were all different from long-term treatment. My aim was to help the patients to talk about their distressing situation and to provide a setting that encouraged them to bring up the underlying reasons for their distress. With respect to technique, there was no opportunity to interpret, get confirmation for hypotheses and work through the problems. Nevertheless, I used my accumulated sense of 'what felt right' and in this way I was able to form hypotheses but further testing their validity with the patient was technically impossible in only four interviews.

It is important to understand that there is a difference between empathic psychoanalytic listening and ordinary everyday business of showing empathy to someone. This difference is at least two-fold. Firstly, analytic listening involves fine tuning of everyday responsiveness. Secondly, we listen to the unconscious with empathy in a disciplined way and that involves meta-psychological understanding. Empathy in itself is not what psychoanalysis is about. Psychoanalytic listening requires us to consider a grid of possibilities as to what is going on unconsciously; it is about exploring the unconscious parts of our mind. And it is also important for us to be able to hear and find the material that does not fit in the hypothesis. It is on this basis that we form hypotheses.

The purpose of the interviews was not intended to make therapeutic changes in patients but to give them, and to myself, a chance to clarify what was going on in their minds with respect to their breast cancer and its treatments. I could not offer any in-depth interpretations in this situation as there was not enough data for that. Long ago Freud (1957 [1910]) warned against 'wild psychoanalysis' stressing that psychoanalytic intervention requires a fairly long period of contact with the patient. Also, there was a danger that these kinds of 'rushed' interpretations would become, more than anything else, an intellectual exercise. Another important point here was that the patients had not come to the interviews to be 'analysed' and from that perspective, as Kvale (2007) has pointed out, to do so would have been ethically wrong and against the idea to provide a 'duty of care'.

4.4.2. Forming Hypotheses

In the following I will give two examples ('Patient A' and 'Patient M') of how I formed hypotheses from the case summaries.

The first example:

'Patient A' represented herself from the beginning as being very anxious and desperate. As her state of excessive anxiety was not proportionate with the physical findings or prognosis of her illness, this made me look for other issues in her present and past life that made her to struggle in this way so much. 'A' wanted to know everything about her illness and treatments but at the same time she could not trust anything she was told. My intuition was that whatever was given to her, it was not enough to calm her down. She felt lonely, even though she was surrounded by many helpful people. 'A' projected her own helplessness onto other people around her, making them helpless when they tried to help her in different ways but without success.

'A's inner loneliness made me hypothesise whether there had been some insecure attachments in her earlier life, so that she could not trust in any kind of beneficial figure who could have helped her to tolerate better her psychological loneliness. The loss of the breast had most probably provoked in 'A's mind memories of some earlier losses or absences with which she had not been supported. There was the current loss of her husband's support as 'A' told me straight away that she had been going through a very difficult time in her marriage when her husband had been distancing himself and leaving her to her own devices. It turned out that 'A's husband had recently lost his mother from pancreatic cancer and his brother had died during the period covering the interviews. So, I hypothesised that probably 'A's husband must have been struggling very much with his own losses, especially when he had had a difficult relationship with his own mother who had abandoned him when he was a child. The husband's unavailability may have been experienced by 'A' as a possible repetition of her earlier environmental failures. At that moment this postulation was only implicit as there was no more information linked with that, except that 'A' had had a difficult relationship with her own mother (this information came from her questionnaire). Psychoanalysis understands that if earlier traumas have not been worked through, they stay potentially active and can be reactivated by later experiences in such a way that the earlier trauma is re-experienced as well as the current one.

In the 'Discussion of Results' section I will demonstrate in a more detailed way how the losses are always more difficult to work through if there were ambivalent feelings (for example love and hate) towards the lost one. It turned out that 'A' herself had had a very disturbing experience, a distressing picture of cancer, as a young schoolgirl when she went to see her beloved grandmother who was

dying of cancer. 'A' herself made a link between her present anxieties of uncontrollable cancer and this memory which she thought had strongly affected her life since then. However, this kind of rational understanding that events from the past have affected one's later life, does not take away the tendency to repeat these experiences, unless the full impact of the earlier events has been worked through. 'A' had also lost her father as a young child and her stepfather in her early teens, and her mother had gone through breast cancer. All these losses made me hypothesise that probably it was very difficult for 'A' to hold onto anything good and trust that it was going to last.

The second example:

'Patient M's continuous nervous coughing was a clear sign for me to think that even though it was understandable for her to be anxious in this situation, there probably were also some other more longstanding issues in her life which were now brought to the surface by her current situation. There was no medical evidence for any organic cause for 'M's coughing. She herself linked it with her stress related asthma. Psychoanalysis sees that these kinds of psychosomatic symptoms have meanings. Grotjahn (1944) referred to Fenichel (1943) who explained how our psychic apparatus has a general tendency to get rid of tension. The aim is to discharge excitation and to re-establish the psychic equilibrium. 'Repression' as a defence tends to block discharges. This creates an unconscious conflict between a tendency to discharge the inner tension and a repressing force to stop this discharge. The more intensive the repression, the higher will be the inner pressure to find other forms of discharges which will serve as substitutes for what has been repressed. Coughing may be such a substitute for relieving an inner pressure caused by repression. This kind of nervous coughing is a rather common symptom (Grotjahn, 1944) which may have different origins. 'M' herself tried to hang onto consoling thoughts that things were not so bad, but her continuous coughing was telling something different. I hypothesised that 'M's anxieties were partly linked with her twin sister's severe mental breakdown following her breast cancer experience five years ago. And probably, this particular symptom of nervous coughing expressed 'M's internal conflict which was her fear of becoming identified with her sister and her sister's fate. There were also some other difficult experiences in 'M's past; such as her daughter's childhood cancer many years ago and her own father's death of a 'mysterious' cancer-like illness. And 'M' told me that her father's death was never mourned as it was never openly talked about in her childhood family.

I further hypothesised that losing the breast may have meant, in 'M's mind, a risk of losing her mind as this was exactly what happened with her twin sister. Furthermore, 'M's own phantasies that her multiple tumours were a result of the biopsies carried out at hospital, were very close or similar to her sister's unrealistic distrustful thinking when she had her breakdown. 'M's terror to trust in anybody came out in her excessive fears about the approaching breast operation and generally, about any minor medical procedures which were done to her. In order to manage these kinds of

terrifying intrusions into her body, 'M' had developed the defence of denial, blocking off anything that provoked difficult feelings in her and keeping control in this way. This was also a possible sign of something intrusive, done to her body, as a child. I hypothesised whether there had been in fact some parental failures in 'M's (and her twin sister's) early childhood for the trauma of moderately early breast cancer to affect their minds so powerfully. If all goes well enough in our earlier life, a capacity to manage difficult, even traumatic, experiences, will be internalised. The role of the environment in providing a child an auxiliary ego, will help her to internalise this capacity. It was very difficult for 'M' to recover from the experience of her illness and I questioned whether that was also a sign of possible early deprivations in her childhood family where she had a vast number of siblings. 'M' was left disappointed and without a trust in any beneficial figures because the extent of her slightly more advanced cancer was not immediately diagnosed at the beginning of her treatments. She was left feeling lonely even though she was surrounded by her large extended family.

4.4.3. Individual Patients

I have kept the case summaries of individual patients short without including more detailed background information than necessary, the main reason being that otherwise these patients would possibly be recognisable. My aim here is more to show how the breast cancer has affected these women's lives in very different ways and how it has provoked some other issues, many of them from their past, to become alive again. These ten women have found very diverse ways of coping with their differing situations, according to their own life experiences.

4.4.3.1. Patient 'A'

'A's breast cancer was detected in a routine mammogram. She did not have any symptoms and her illness was discovered early and without any detectable spread into lymph nodes. She needed lumpectomy, radiotherapy and endocrine therapy. 'A' was a very expressive and psychologically reflective woman who had caused a bit of a hassle amongst the nurses in the Breast Unit because she wanted to know everything but could not trust in anything. This was due to her heightened anxieties and her own internal experience that she was left totally on her own. However, she clearly was not on her own when she wanted to know everything all the time and had many helpful people around her. 'A' was easily in tears and crying. She felt that she had not been supported at all by her husband or other family members, not even by the nurses in the Breast Unit. However, I wondered whether people found her anxieties a bit overwhelming and whether it was difficult to support her when she could not trust others. In her internal world she felt lonely and it was my impression that whatever was given to her, it was not enough.

I wondered how much 'A's husband struggled with his own issues and found it difficult to give more support for his wife. He had recently lost his own mother from pancreatic cancer and his handicapped brother also died during the time of the interview process. 'A' and her husband had had severe marital problems in recent years which had already made 'A' feel isolated from the rest of her family. She felt that she had been ignored a long time by her husband who had, in 'A's mind, also provoked the children to be against her. She blamed her husband for the marital breakdown and she even had a phantasy that his neglecting behaviour may have been the reason for her cancer to develop.

'A's maternal grandmother had died of tongue cancer when 'A' was in her early school years and her memory of seeing her dying beloved 'gran' had had a huge impact on her. Since that incident 'A' had always feared tongue cancer as long as she remembered. She had lost her father at the age of four and her stepfather in her early adolescence. 'A's mother, with whom she had not had a good relationship, had had a breast cancer twenty years ago but was still alive. 'A' herself had had pre-cancerous cells in cervix thirty years ago.

After the treatments were completed in the Breast Unit, 'A' was terrified of her cancer coming back. She was bewildered and found it very difficult to trust in her future. As she had not had any symptoms in the first place, it was difficult for her to feel any confidence that the cancer was not starting again somewhere else in her body. It was very anxiety provoking for her that nobody could turn around to her and say, 'you are cured'. 'A' struggled with a kind of basic ontological insecurity. She had lost three close family members in her childhood and young adolescence; her father, her stepfather and grandmother. In her present-day situation, the loss of a part of her breast had evoked these previous childhood losses and, in this way, increased her anxieties. None of us know what is going on in our bodies but most of us will find ways to manage this kind of 'not knowing'.

'A' was trying to put all her worries in a little box but thought that she will never forget her experiences. 'A's fears about the cancer returning in the future was also linked with her fear about the future of her marriage. Whether she could trust in a better marital relationship with her husband and in a cancer-free future. 'A' was frightened to be left to her own devices after her treatments ended but was able also to appreciate all the help she had received, especially from her consultant. She also managed, in the end, to acknowledge at least a little bit of her husband's own struggles and why it had been so difficult for him to be more emotionally present for her.

4.4.3.2. Patient 'B'

'B's cancer was found in a routine mammogram and she too did not have any symptoms. She had mastectomy and breast reconstruction with a flap from her back, followed by endocrine therapy. 'B'

was a very talkative woman, but her manner, somewhat mechanical, was to concentrate on concrete details and to take a bit of a distance from her feelings. She often had a very rational and practical approach. Sometimes she had tears in her eyes, but she never cried more openly.

'B's husband had died eight years ago of leukaemia and had been treated in the same hospital which understandably brought very painful memories into her mind. 'B' felt that life with the rest of her family had almost stopped after her husband's death and her house was still full of 'dead people's stuff'. She also lost her widowed mother a few years later and some of her own extended family members lived in another country. Her younger daughter had broken down after losing her father and 'B' had been her main carer for all these years. 'B' saw her daughter almost like an invalid, not being able to cope physically or mentally with hardly anything. There was a plan for 'B' and her daughter, to move to another part of the country but 'B's mind, like her house, was full of deadness and she could not progress in her life. 'B's cancer diagnosis was like a tip of the iceberg in this situation where she already was struggling in order to keep everything together.

'B's present situation with her own illness was very similar to the one where she lost her husband. In the past she had to manage on her own and contain all the anxieties about her husband's terminal illness, the real nature of which had not even been told to him, in its first stages, let alone to their daughters. 'B's own breast cancer had now brought back some of these difficult issues, regarding the loss of her husband, that had not been worked through in the past; as she said, her house, like her head, was full of dead people's unsorted stuff and there was no space for her own needs. When 'B' had her cancer diagnosis, it was not just her younger daughter whose situation became worse but also her older daughter started to struggle and had to stay on sick leave for many weeks.

Towards the end of the interview process 'B' became increasingly angry with the outpatient and council care services who, she felt, had let her down and couldn't do anything 'right'. But probably her anger also belonged to her adult younger daughter who constantly controlled 'B' with her own, often excessive, needs. This daughter even denied that 'B' had ever told her about the cancer. 'B' once admitted to me that coping with her own illness would have been much easier for her if she had been on her own because then she would have had more energies to look after her own needs. There must have been also a resentment, somewhere in 'B's mind, towards her late husband who had left her to sort out everything on her own, without any support coming from her extended family whose members were either too old to help or living in another country. Probably now it was somehow easier for B to see her younger daughter as somebody so fragile and helpless, instead of 'B' being more in contact with those kinds of feelings in herself.

4.4.3.3. Patient 'C'

'C' had a tumour detected in a routine mammogram; and as in the previous patients, she did not have any symptoms. She had missed, because of her work pressures, a couple of her previous routine mammograms and nearly missed this one as well. 'C' was a very down to earth woman who had a practical outlook and found it difficult to show her feelings more openly and admit her own vulnerability. I questioned whether she first even played down the importance of her breast operation and was consoling herself that her tumour had been so small that 'they got it out already at the biopsy'. However, she was offered radiotherapy which she declined to have because it would have caused 'too much hassle'. She was too busy at work and concerned that her treatment sessions would have given her an unfavourable reputation amongst her colleagues because then she would have needed to take some extra time out from her work. She also smoked and was worried that her heart and lung would have been in danger in radiotherapy. And she thought that if she had had radiotherapy, she would not have had the energy to do her dementing father's weekly shopping and the babysitting for her daughter. 'C' found it difficult to let go her 'usual' identity as her family's matriarch who was always looking after the others.

'C's breast cancer diagnosis was a shock 'coming out of the blue'. It brought the thought of dying very much to her mind as she was now exactly at the same age as her own mother when she died. 'C's illness also evoked recollections of the time, thirty years ago, when a benign lump in her breast was found. Nothing was explained at that time to her and she felt that she was just like 'a piece of meat'. 'C's tumour also brought back memories of her stillborn baby. He was 'not a real baby but a lump that needed to be got rid of'. In hindsight, she thought, that it was like a cancer that needed to be taken off. 'C' never saw her baby. He was buried at the bottom of somebody else's grave. It took a long time before 'C' stopped thinking about her loss. When the baby was not shown to her, she had phantasies of him being something horrible and deformed, like a cancer. 'C's mother also had had two very late miscarriages and her mother nearly died.

'C' was the eldest of her large unhappy childhood family which was one where her parents argued constantly (this information came from her questionnaire). In her own extended family, she had been a driving force, always looking after the others; her disabled husband, her dementing father, grandchildren and her sister whose son was killed accidentally a few years ago. I was left feeling that it was very difficult for 'C' to be aware of her own needs. She told me in a great length about her childhood memory, a memory of her doll's house she had to leave behind when her family moved away. I wondered whether the doll's house might have represented to 'C' the child and dependent needy part of her that she had had to disown during the course of the years. Others depended on her, for example at home and work, and she was terrified of her own neediness. In this mechanism

of projective identification, 'C' had projected into the others the parts of herself that needed be looked after. She then looked after the dependent aspects of others, having no expectation that she herself could be looked after.

Towards the end of her treatment 'C' recognised that the family dynamics had changed a bit and she was able to accept more help coming from others. Luckily, her daughter had also bought her a new doll's house and 'C' was looking forward to decorating it after her retirement. After our last session had ended 'C' was already half-way out into the waiting area, when she suddenly turned around looking at me and timidly announced 'I will miss our talking'.

4.4.3.4. Patient 'D'

'D' was the oldest of the women, in her mid-70's. Her cancer was detected in connection with another condition. After the lumpectomy she needed radiotherapy and endocrine therapy. One of the most difficult aspects for 'D' in her treatment processes, was her radiotherapy sessions; not only did she have to travel a long distance, but also, she had to face at the hospital other cancer patients with more advanced stages. She had phantasies about the cancer being contagious. 'D' was a very private person and did not want her breast cancer to become a 'public thing' and she did not want other people to be emotional towards her because of her illness. Seeing other vulnerable patients or emotional people around herself would have been difficult for 'D' because that kind of situation could have possibly touched her own potential vulnerabilities. 'D' told me that she had to be independent already at an early age because her mother was suffering from chronic heart problems throughout her life, and interestingly, 'D's husband also had troubles with his heart and needed to be looked after by 'D'.

I saw 'D' twice at her home because of the issues with the travelling but also, because her mobility was not so good anymore. The cancer itself did not scare 'D' because she got support from her strong faith. It was more how to manage the other family members that worried her greatly. All her life 'D' had been a very active matriarch in her big family, sorting out all the problems of others and fixing different things. Her professional career had been also one in which she was in charge and responsible for resolving different issues. Clearly, 'D' had worn the 'trousers' in the family. Now the cancer had taken off her 'trousers' and made her realise that she was vulnerable and could not rely on herself in the same way as in the past. Her fragile husband found it difficult to cope and had 'divorced' himself from the word 'cancer' because in his childhood, cancer meant death.

'D's family was divided, two of her younger adult children being very anxious and the other two distancing themselves, emotionally and physically. The cancer brought back 'D's previous losses;

both her parents had died of cancer, father of prostate cancer and mother of liver cirrhosis, due to the medication she had to take for her heart condition. One of 'D's sons had had mental problems and had died accidentally as an adult. 'D' thought that the loss of her son, many years ago, still greatly affected her family, especially her two younger children who now became very anxious because of their mother's breast cancer and because of the fear of losing her. 'D' also had had, many years ago, a stillborn baby, a baby boy whom she never saw and who still quite suddenly managed to provoke a powerful unexpected emotional reaction in her in the interview situation. She was quite surprised that she still had such a strong response for that very old trauma. This made me question whether 'D' always had needed to be so strong that she never had given herself a chance to mourn even her lost baby.

4.4.3.5. Patient 'F'

'F's cancer was detected in a routine mammogram. It was a shock for her but, since last year, she had felt 'terrible' and was not happy with the way how she physically looked. She needed lumpectomy, reduction of her healthy breast and radiotherapy. 'F' was a thoughtful well-travelled woman in her job who was very much in touch with her own feelings and experiences and very able to reflect on them. In her life she had had many losses of others from cancer and these losses became now very much alive; her father's and ex-husband's lung cancers, her brother's stomach cancer and her cousin's breast cancer. 'F' had her radiotherapy in the same hospital where her father had received his treatments. Her mother had also had a breast cancer even though she did not die of that. The 'worst thing' in her life had been to lose her fit and sporty young brother to an aggressive form of cancer.

'F's biggest worry was now how to tell her adult son about her own cancer without making him overly distressed because he had lost his own father for cancer ten years ago. 'F' was living on her own and had always been very independent. She had a circle of good friends but one of them had said in some connection to 'F' that she 'rather crawled than asked anybody to help her'. However, 'F' in this new situation with her illness, allowed herself to accept her own vulnerability and receive help offered by her friends. She had felt very lonely recently as her long-term relationship had broken down and her son was moving to his own home.

'F' was angry with her body letting her down, especially, when she had been always very healthy and tried to look after herself. She was anxious whether 'something more was going to come'; whether she was going to have an additional experience of cancer when there was a question of a melanoma in her finger. Nevertheless, 'F' had decided that she was not going to torment herself even though she had a query whether her HRT treatment which she had taken up for a long time,

was somehow responsible for bringing on her cancer. But on the other hand, the HRT had made such a difference for her general wellbeing. In the past, she had done some voluntary work and now, in order to make something positive out of her own struggles, she wanted to carry on that work. After going through her own experience of cancer, she actually felt stronger and was able to appreciate what she had had in her own life. After all, 'F' considered herself to be lucky because she had been healthy, had had a long life and her cancer was detected early compared to her family members whose lives had been cut short. She was able to put herself in their position and empathise what they might have gone through with their illnesses.

4.4.3.6. Patient 'G'

Even though 'G' found a lump herself, she did not expect anything bad when she came to the hospital. She was in a total shock and turmoil when the results were given to her. But she faced even a worst reaction at home from her husband who totally collapsed after receiving her news. The wife's illness most probably brought back the husband's own losses; his mother, father and brother all had died of cancer. He was only one year old when he lost his father. Some other traumatic incidents had also happened recently in 'G's family, undoubtedly raising the anxiety levels. Their son's ex-partner had recently died of brain tumour, a daughter-in-law was suffering from advanced neck cancer and a cousin had a terminal lung cancer. This made 'G' wonder whether she was entitled to her own worries at all when the others were currently in a much worse position.

'G' was a quite serious woman, talking slowly. She had had her previous cancer frights when she had gone through cervical cancer as a young woman and later had a hysterectomy. She also had suffered from depression and still was taking some mild form of antidepressant. 'G's medical procedure was different from the other patients' one in this research. She had to be first on endocrine therapy for over six months in order to shrink her tumour before the surgery and radiotherapy. The waiting for the operation was a very distressful time for 'G' because she could hardly stand the idea of 'it still being there'. She could not talk about her worries to anybody because talking made her even more upset. But nevertheless, in her own mind, she was agonising whether the cancer had spread somewhere else during this 'waiting time'. 'G' did not know what was going on in her body but at the same time, she really did not want to know, and did not ask for more information. In that way, she was putting herself in an additionally helpless position.

'G' was hugely relieved after her operation had been performed and she had found out that her cancer had not spread. Going to radiotherapy was a disturbing experience for 'G' because she saw other cancer patients in a much worse situation. At the end of all her treatments 'G' felt that she was almost abandoned by her 'little hospital family' and left to her own resources. This 'abandonment'

probably was also linked, more unconsciously, in G's mind with her unhappy childhood experiences. After her parents' divorce her mother was financially unable to support the children and 'G' with her siblings were sent to a foster carer for a year (this information came from the questionnaire). She may have experienced that earlier time away from home as an abandonment by both her parents. Now 'G' was suffering from all kinds of physical aches and pains in her body which, she thought, were due to continuing endocrine therapy. But I wondered whether that was also the only way that 'G' was able to show her neediness and ask for help, through her body, not by words.

4.4.3.7. Patient 'J'

'J's cancer was detected in a routine mammogram. She did not have any symptoms, but the cancer turned out to be of a more aggressive type. After having had surgery, she was going to have chemotherapy, radiotherapy and endocrine therapy. 'J' was a very sensible woman who was looking at her situation in a matter of fact way and pragmatically. She became aware of her own mortality but was thinking about it in terms of reviewing her will, sorting out her bank account and choosing her head stone. Sometimes she seemed to cut off her feelings totally and almost made fun of them. She thought it was better to laugh about the whole thing, 'otherwise you would be crying'.

This kind of humour must have been linked with 'J's previous experiences of cancer in her late teens. Like now, she did not have any outward symptoms that something was seriously wrong in her body. Her experience of lymphoma, forty years ago, must have been a terrifying encounter for a young girl when nothing was explained to her and instead of staying at the hospital for a couple of days, as she first had expected, she ended up staying there for many weeks. She developed a habit of fainting when minor medical procedures were needed. She also fainted now when her dressing was taken off. I wondered whether that had been 'J's way to cut herself off from mentally overwhelming painful experiences. She did not have any children, due to her previous heavy-duty chemotherapy effect on her ovaries, which must have been a further big loss for her.

'J' had been a driving force in her second marriage and her husband took the news of her breast cancer in a much worse way. The couple had experienced many other losses in the previous year; 'J's own mother and her husband's mother had both died four weeks apart and her husband's brother-in-law had died of brain tumour. Her cousin had died of a lung cancer, and a friend's husband of bowel cancer. 'J' did not want to have her widowed sister-in-law to visit her because she could not tolerate her crying and missing her husband. This must have been threatening for 'J' as she had quite successfully managed to block off her own distressful feelings. She regarded herself as a positive person but whether this happened at the expense of having to keep her vulnerable parts

away, either dissociating from them by fainting or projecting them and seeing them in another person, like in her sister-in-law.

Chemotherapy frightened 'J' because she knew that she was going to lose her hair. She wanted her husband to shave her head before the actual treatment started, so that she could feel that she was in control of the situation. Being in control was very vital for 'J'. That was of paramount importance because in her previous cancer experience, she had felt that she was left with no control at all. She thought that after all, 'not knowing' was actually much scarier, than 'knowing'.

4.4.3.8. Patient 'K'

'K's cancer was discovered in a routine mammogram, and again, she did not have any symptoms. Her one breast had always been problematic, lumpy, mis-shaped with a painful nipple but the other breast which she thought was healthy, did in fact contain cancerous growths. 'K' firmly felt that her good breast had betrayed her and having her diagnosis was a terrible shock. She had a mastectomy with implant, followed by endocrine therapy. 'K' was a talkative woman, very much in contact with her feelings and easily crying. She said she was crying more about her older sister because they had been always very close to each other. Her late sister had had breast cancer nearly 30 years ago. She had just had a simple mastectomy and prosthesis, no reconstruction. According to 'K' her sister 'suffered' from that experience for the rest of her life.

At the beginning of the interviews 'K' told me that she was not sure whether she wanted to come to see me at all because her sister had never had a chance to talk to anyone. Her sister should have needed counselling because the sister had been torturing herself for the rest of her life by the belief that she had a cancer somewhere in her body. She did not have a cancer, but she died a year and half ago of another condition, for which she refused to have any treatment. 'K' said her sister was disappointed with her life, and I thought, probably depressed too. 'K' had lost contact with her father as a young girl when her parents separated. And 'K's mother who was a heavy smoker, had died of cancer at a relatively young age. 'K' and her sister nursed their mother for nine months at home till her death, pretending that she was waiting for an operation. When her mother died, she was 'riddled with cancer'; she had so much cancer in her body that there was no way of knowing where the primary tumour had been. This experience had left 'K' devastated. After their mother's death 'K' and her sister became 'very, very close'.

'K' always 'knew' that she herself was going to have a cancer. There was an identification with her sister who had a 'life sentence' of cancer. I also wondered whether, in 'K's mind, there was no way she could have dis-identified herself from her sister; her own cancer was now going to be her own

'life sentence'. She felt guilty because she had always been the lucky one, the healthy one when her sister had been suffering. 'K' told me that the cancer had now taken over her life and it was also her worry, like it was her sister's, that it will come back or that it already was somewhere else in her body. It may have been that somewhere, more unconsciously, in 'K's mind, there was also a fear that her fate was going to be similar to her mother's.

4.4.3.9. Patient 'L'

The youngest patient 'L' found a lump herself which turned out to be an aggressive type of cancer and it had spread into a lymph node. The diagnosis was a surprise for 'L' even though she 'kind of knew' that something was wrong. She had a skin sparing mastectomy with implant, reduction of her other breast, chemo- and radiotherapy and endocrine therapy. She was also going to have a breast reconstruction using her own muscle, in a few years' time. 'L' created a lot of hassle in the Breast Unit because of her own psychological vulnerabilities and her past experiences of being abused. However, if these issues from 'L's background had been recognised enough in advance, it definitely could have helped to calm down her state of mind.

Because of her difficult encounters at the hospital, 'L' refused to come to see me to the interviews there. I then suggested going to see her at her home which in hindsight was a good arrangement as she felt safe in her own domain. 'L' was a very talkative woman, easily expressing her feelings but also very able to reflect on her thoughts. She had felt 'attacked' by a consultant who gave a second opinion of her surgical procedure which was different from her own consultant's recommendation. 'L' understood that the second consultant recommended a simple mastectomy which meant to her having no breast at all. This was just devastating news. A very similar kind of scenario was repeated later on when 'L' also felt 'attacked' and 'ignored' by two oncologists and a nurse in another hospital where she was having her treatments.

'L's background history could have been very helpful for staff members to have known in these situations. The breasts had always played a very important role in 'L's life because she felt that these were the 'only parts' people liked in her. 'L' had been abused as a child by her physically violent parents and later by a 'paedophile' and now she felt threatened to be abused again by this second consultant because she felt worthless and not heard by him. This threat made her to behave aggressively towards the staff members who tried to help her. 'L' told me that losing her breast would have meant 'losing everything', as if her whole life was in her breast too. She would have been left with an empty space and that situation would have been intolerable. The total loss of her breast would have reminded her of the empty and dead space, she was left with, after delivering a stillborn baby boy some years ago. She had a breakdown after this incident. And even now, the lost baby

was daily in her mind. In connection with the breast procedure 'L' was told that there was a risk of infection if she had two operations at the same time. However, 'L' thought that the real risk was that she would have killed herself if she had been left with only one breast. If she only had had one breast, she would have felt like a weird freak and her 'good and acceptable' identity as a woman would have been lost.

'L' already had a mistrust in the medical profession. In her mind, she lost the baby because of the 'doctors' mistakes'. After her breast operation that was carried out following her first consultant's recommendation, 'L' felt 'amazing'. Nevertheless, she was 'super nervous' when starting the chemotherapy which then had to be interrupted because of different complications. After the treatments, 'L' was left asking whether she was cured or not. 'Not knowing' was the biggest problem and she couldn't afford her anxieties to get any greater.

4.4.3.10. Patient 'M'

'M's cancer was detected in a routine mammogram and one lymph node was affected. That was a big shock for her as her physical health had always been good. 'M' herself had felt a lump for some time but thought that it was just a cyst. At the early stage of her treatment the plan was to operate on the small lump and then to have some radiotherapy. 'M' was a lively talkative woman who told me that she was not overly worried about her situation; but her body was telling her otherwise. There was lots of coughing that she attributed to her stress related asthma which had got worse after she had received her diagnosis. However, 'M's operation was cancelled because new cancerous lumps were found in the MRI scan of her body. The uncertainty of those few weeks, the 'not knowing' what was going to happen to her, was a 'horrible, terrifying' time.

'M's twin sister had had a breast cancer exactly five years ago and following that, she had had a severe mental breakdown; she had to be sectioned and hospitalised. 'M' was now very worried of becoming identified with her sister. She was frightened of the idea that losing your breast might mean losing your mind too. And she told me quite a few times that she did not want to take the same route as her sister. 'M' was choking with tears when she was recollecting how her now adult daughter had had a tumour in her brain stem in her early childhood. And 'M's father had died 'like a cancer patient' many years ago. He had been terrified of cancer, had refused the operation, and the reason for his death was never talked about in 'M's childhood family. 'M' too had embraced a way of just blocking off difficult things from her mind and not wanting to know of them. 'M' was absolutely terrified of even a thought about any physical procedure. And perhaps there was a wishful phantasy in 'M's mind that if she did not think about it, it was not going to happen.

'M' then lost her trust in the doctors in the Breast Unit because the extensity of her illness had not been detected right away at the beginning of her referral. She was also convinced of her own phantasy that her cancer had spread because 'they cut into it'. She needed chemotherapy which had to be interrupted due to the complications. Her body had had enough, and she was suffering from pain everywhere. Nothing had worked out in the way she had expected it to. 'M' had lost her role as an actively functioning matriarch in her household. She felt emotionally on her own, even though she was surrounded by her big extended family. 'M' told me that if she started to cry, her husband did that as well.

5. DISCUSSION OF RESULTS

5.1. General Remarks

The aim of my study was to offer psychoanalytic understanding on the ways in which women managed their breast cancer diagnosis and its treatments. My starting point for this study was the clinical observation by the staff members in the hospital's Breast Unit that the level of psychological distress amongst their patients bore little or no relationship to the stage or prognosis of their illness. This remark, made by one of the consultants there, led me to question that, if it was not the severity of physical illness or extent of treatment explaining this angst, there could be then some other factors in a woman's life which will determine the level of her distress.

My study was to explore, from a psychoanalytic perspective, some underlying, less obvious factors which could vary psychological distress. My findings have clearly indicated that the patients going through their illness of breast cancer and its various treatments, experience different kinds of anxieties linked with their physical condition. However, what was interesting to discover, was, that the surgery in itself and the other breast cancer treatments were not a major source of distress for most patients. Above all, as I have shown in the 'Results' section, it was the distress linked with memories from different kinds of losses in the patients' past and the emotional loneliness which this illness also evoked in their minds. It is important for me to repeat here that I did not specifically ask from the patients about issues linked with losses and loneliness, but these sources of anxiety and distress were talked about spontaneously.

In the 'Results' section I have demonstrated, using psychoanalytic theory, how the patients, as a group, coped with the different stages of their illness process and I have presented short case summaries of each individual patients. In what follows, I will add now more theoretical viewpoints for my two major findings; losses and loneliness.

5.2. Managing Losses

As my results have shown, the loss of breast or parts of it, evoked memories in the patients' minds of other kinds of losses. Here I will firstly look at so-called 'normal losses' in an individual's development and then secondly, how she will manage later losses in her life.

5.2.1. Normal Losses

Firstly, there are so-called 'normal developmental losses' in everyone's life and we have to manage them in one way or another. In normal psychological development, the child needs to give up some of her earlier behaviour patterns which are no longer age-appropriate so that her emotional and cognitive development can progress; for example, the infant needs gradually to differentiate and separate herself from her mother and find her own individuality. Later, the child has to increasingly accept the so-called 'Oedipal' situation, the reality of the parental relationship and its sexual implications, from which relationship she would be excluded. And later, in her adolescence, the young person has to leave behind her childhood parents and gradually establish her identity with includes her own sexually mature body. In this way the child's emotional development is characterised by recurrent experiences of losing and regaining (in a new form). If these normal developmental 'losses' are not negotiated, they will have an impact on the person's future development. I did hypothesise whether some of my research patients who clearly were struggling in their stressful situation, in fact may have experienced some earlier failures in negotiating their normal developmental 'losses'. In order to move on and progress in our life, we need to lose some earlier structures so that we can make room for the new ones. As Robinson (2018) has shown in the case of mourning death, it is important to understand that these kinds of 'normal losses' which have happened in the person's past development, are unconsciously still present in our minds when we experience losses later in our life.

5.2.2. Difficulties in Mourning

The patients mentioned many kinds of losses that had happened in their lives. The loss of breast or parts of it, not only aroused fears of losing one's own life (the fear of death probably plays a part in loneliness throughout our adult life) but it brought alive again many other kinds of losses from the patients' past; their own illnesses, other people's illnesses, deaths of close family members and friends, losses of relationships and changes in roles such as being the matriarch of their families, retiring from work and children leaving home.

What is of paramount important in these losses, is, that they have to be mourned by the person who is being left behind. Freud (1957 [1917]) made a distinction between mourning and melancholia which are two different responses to a loss. Freud regarded mourning as a normal psychological reaction to the loss of a loved one. This can refer to the physical loss of the person or to the loss of the ideal that one had attributed to the person. In mourning the world becomes temporarily poor and empty to the person but in melancholia, it is not the world which loses its liveliness but the person's

ego which now finds itself useless and incapable of achieving anything worth value. In this pathological state there is an identification with the lost person due to different ambivalent feelings the individual has had towards the lost one. Inconsolability, when the person is incapable of being comforted, is the ordinary human reaction to the loss (Robinson, 2018). But usually, in time, this kind of state is gradually losing its intensity and the person will gradually find her usual 'self' and capacity to function again in everyday life. It is common for us to feel sad around anniversaries of bereavements or to relive earlier deaths over again when we experience a new one. On the contrary, this kind of process does not happen in melancholia where the person is stuck and unable to move on without external help.

It is not unusual that the loss of a person may also provoke anger towards the lost one who has left the person in question. The individual left behind may feel totally abandoned and helpless in her new situation; this was the case with 'B' who had lost her husband from an aggressive form of cancer many years ago. After his death 'B's and her children's life got stuck. 'B's anger towards the 'ineffectual' social and outpatient services during her own cancer treatment was a displacement from her anger towards her husband who had left her trapped with her resentment and inability to move on in her life.

The situation will be even more complicated if the person being left behind feels, consciously or unconsciously, that she had somehow – through her own anger - caused the death or been responsible for it; and this is often very common especially amongst children. This kind of ambivalence, when there are opposite kinds of feelings towards the lost person, will then prolong the mourning process or make it even impossible if there are lots of guilt feelings involved. 'K', for example, was now identified with her late older sister who had suffered for much of her life from fears of recurrence of her breast cancer. 'K' felt guilty about always being the healthy one, which made it difficult for her to mourn the quite recent loss of her sister. Mourning her sister would have unconsciously meant for 'K' some kind of liberation and a more enjoyable future life. But this in turn would have increased 'K's guilt feelings as she would have been again in a 'better position', being able to get on with her life. Whereas now, when 'K' identified with her sister by suffering from similar illness in a similar way as her sister did, she was able to satisfy her feelings of guilt. Many of the earlier losses came so powerfully alive in the interviews, as for example 'C's, 'D's and 'L's stillborn babies, whom had not been mourned enough in the past. Perhaps now, the loss of a 'bad' breast or parts of it (because of the cancer) reminded these patients of the time when their 'good' breasts were ready to feed a baby who was lost. The situations where the losses had not been mourned enough, probably had been one of the reasons, a more unconscious one, why the older women wanted to share their experiences with me.

Druss (1986) has shown that a person who is struggling to manage her serious physical illness and move on in her life, can find it difficult to accept the loss of her health. Her present illness will be repeating the memories of her earlier losses in which the same feelings were involved but cannot be now faced again. In this new situation she will feel anger towards others, for example authority figures and parental substitutes, such as staff members at hospital, who should have been different and protected the patient from the loss of her health. The person might now blame others for various things and be envious of others' better fortune in health. 'B', for example, felt increasingly deprived and disappointed with the social services because of their 'minimal' support. Druss pointed out that underneath this kind of behaviour, there is the ultimate blame at the person's parents who, in her phantasy, had 'promised' her a perfect life, free of pain. Now when a health 'disaster' happens, she (in Druss' words) may unconsciously feel betrayed by her parents and the loss of her health will then provoke some earlier losses in her life. Druss (1986) continued that there would have still been in a person's mind a childhood phantasy of her omnipotent parents that 'all losses are restored by them and all sorrows end'. However, I would say that in this kind of scenario there probably have been also real parental failures and these kinds of magical expectations stem from parents' incapacity to contain their child emotionally and help her to manage difficult emotions such as tearfulness, anger and disappointments, linked with the imperfections of life. If the child cannot gradually manage a reality confrontation that her parents are not omnipotent and in fact, they may have some defects, she will experience problems in managing future losses later in her life. Similarly, Guntrip (1969) has emphasised that the individual who has remained without secure enough ego-supports in her early infancy, will be very vulnerable later in her life if her external supports fail, and she will be confronted by losses.

5.3. Managing Emotional Loneliness

5.3.1. Understanding the Concept of Loneliness

To understand the patients' loneliness, which proved to be so alarming in my study, I will give a brief picture of this topic from a psychoanalytic viewpoint. Interestingly, many authors have acknowledged that so little has been written about loneliness in psychoanalytic literature (for example Ferreira, 1962; Rubins, 1964; Satran, 1978; Erlich, 1998). Rubins (1964) concluded that it is one of the least understood and least satisfactorily conceptualised psychological phenomena we are dealing with. The reason for this is that loneliness is a very subjective experience, difficult to communicate, identify and define. The author summarised that it is often attached to other forms of experiences such as isolation, solitude, aloneness, separation, alienation and estrangement.

Freud rarely wrote about loneliness. In 'The Uncanny' (1955 [1917-19]) he questioned 'the origin of the uncanny effect of silence, darkness and solitude'. He concluded that they were the elements belonging to infantile anxiety in situations where the child is aware of the absence of a loved person who looks after her (usually her mother). Most of us human beings will never become quite free from this feeling (Satran, 1978). For this sensation Freud used the German word 'das Unheimliche' which means something that is 'not home-like'. Another word describing this feeling is 'un-mothered loneliness' used by Bertrand Russell, the English philosopher. This longing for the familiar comforts of home was much later acknowledged by Sandler (1960) when he recognised the importance of a person's childhood home. He indicated that familiar and constant things in the child's external environment will carry a special affective value for her, and this kind of 'scaffolding' helps the child to maintain the minimum level of feeling safe.

Many authors have differentiated 'negative' from 'positive' loneliness. Ferreira (1962) referred to Aristotle who announced that no one would choose the condition of being alone since a man's nature is to live with others. Ferreira differentiated 'loneliness' from 'aleness', seeing the first one as a passive destructive state where the person feels separated and isolated, totally on her own and all emotional ties being cut off. On the contrary, 'aleness' is radically different from 'loneliness' because it is ego-syntonic, acceptable to the 'self', and potentially a constructive state which the person can regulate herself. Even though nearly all patients (except one) in my study found their emotional loneliness as something negative, a few of them, like 'D', 'F' and 'J', were able to see also some positive aspects and this experience made them feel stronger. Rubins (1964) also distinguished two kinds of loneliness. By the primary 'real loneliness', he referred to the basic infantile condition where a young child is alone and helpless in the world and by 'secondary loneliness' to a loss of a love object from which the person can recover through mourning.

Fromm-Reichmann (1990) called positive aleness 'creative loneliness' because most works of art are created in this kind of constructive state of loneliness where the person will be in touch with her 'oceanic' feelings to merge with someone. Fromm-Reichman concluded that 'creative loneliness' is temporary, self-induced and alternatively sought out or rejected. She extended this kind of positive loneliness also to situations where we have lost a loved one. Through mourning we introject the lost person into our minds and this process is counteracting our loneliness and making room for new relationships. Fromm-Reichmann regarded 'real loneliness' as a non-constructive state which may ultimately lead to pathological processes. Many well-known authors (for example Spitz, 1945 and Anna Freud, 1958) have highlighted the risks of a young infant being separated too early from her mother, before she is ready to find other forms of satisfactions for her needs, and this kind of situation could lead to essential loneliness and depression. 'Maternal deprivation' plays a crucial part in psychopathology and in this way early losses (separations from mother or the primary caretaker)

are closely linked with loneliness. A child whose needs for close and intimate relationship with mother are not met, is bound to remain emotionally 'handicapped' and feel lonely (Ferreira, 1962).

5.3.2. The Capacity to Be Alone

In the following I will present Winnicott's (1958) thinking about positive loneliness which (as mentioned earlier) some of the research patients were able to experience when they were gradually re-finding their inner strengths. Winnicott regarded our capacity to be alone as one of the most important signs of maturity in our emotional development. He saw this capacity being gradually achieved in the early stages of the infant's development. Winnicott's (1960) famous words were that at the beginning, 'there is no such thing as an infant'. By this he meant that whenever one finds an infant, one also finds maternal care, and without maternal care there would be no infant. In baby's phantasy, there are no boundaries between her and her mother; she and her mother are one single unit. Mother's different physical ways of handling and holding her infant act as an 'environmental mother' who is helping and supporting the infant gradually to find her physical and psychological boundaries. Winnicott indicated that the child's immature ego is naturally balanced and supported by her mother. Little by little, the infant starts to tolerate being left on her own, often with the help of her using a 'transitional object', such as a soft toy or a blanket for example, which represents her mother. The 'transitional object' is like a bridge helping the infant to feel linked with her mother when the mother is not physically present. The infant will slowly internalise her mother into her mind as a supportive figure who can help her in times when she feels lonely or she is in distress. In internalisation the child is working through repeated experiences of being separated and then reunited with her mother. Such successive separations from the important person creates fear in a child's mind that when losing that good object, her mother, in her external world, she may also lose her internal good mother. Gradual setting up a good internal mother figure in the child's ego, helps her ego to become stronger so that she can tolerate her mother's absence without excessive anxiety.

Our capacity to find this kind of beneficial figure, always present in our minds, is a lifelong experience which we all need, especially, when we are struggling in a stressful situation, such as facing a serious physical illness or other kinds of losses. In this way, the supportive environment is mainly built into our personalities and leads to the vital ability to manage loneliness and losses in stressful situations. This experience is based on the residue of having a mother who temporarily identified herself with her infant and who, for the time being, was only interested in caring for her. Winnicott (1958) regarded this 'capacity to be alone' as a positive developmental achievement and concluded that the individual needed to be sufficiently integrated so that she can be aware of her dependency needs and have trust in others whom she sees separate from herself. This issue was also very important amongst my research patients, some of whom, with the help of their internalised beneficial figures,

were gradually re-finding their usual defences and managing their difficult situations. 'F' was proud of herself and felt stronger when her illness had helped her to enjoy more of her own company and she was able to support other cancer patients when volunteering at a hospital. Both 'D' and 'J' also needed 'me-time' and were able to enjoy at least some periods in their stressful situation; whereas many others felt stuck and frightened to move on in their lives. This important ability to tolerate and manage aloneness, which Winnicott called 'being alone in the presence of someone' (meaning that there is a supportive figure in a person's mind), has been given different terms by other authors; Anna Freud and Margaret Mahler called it 'object constancy' and Melanie Klein 'integration of psychical life'.

5.3.3. Childhood Longing for 'Merging with Mother'

In my study, the physical illness was threatening to leave some of the patients in a regressed state, helpless and hopeless without any trust in their own resources but longing for the Breast Unit to be the 'omnipotent mother' who will respond perfectly to their needs. In order to understand this kind of situation more, I will explain how psychoanalytic theory understands our lifelong wish to be 'totally' understood by another. Here I am referring to the pioneering psychoanalyst Melanie Klein (1963) who acknowledged that the inner sense of loneliness was experienced by everyone because it is a result of our childhood longing for 'merging with mother'. Klein was referring here to a kind of perfect state of union between an infant and her mother that is not possible for us any more as adults. There is an unsatisfied longing in all of us to be understood without words, just as it should have felt in the earliest relationship with the mother who would have understood her infant by simply looking at her. The young baby in this state of being, is merged with her mother and there is no sense of differentiation between her 'self' and her mother.

Hence, this eternal longing for 'merging with mother' originates from an infant's very early distress when separated from the source of relief of her tensions, a source she is dependent on (her mother). This kind of situation is not only linked with young children but remains also in adulthood and is experienced to some extent by every one of us when we feel helpless; we long for to be relieved of our tensions by someone else who could take responsibility for our well-being. Our longing for this kind of 'reunion' is never going to be satisfied in the same way as it happened in our infancy and for that reason we are left with ultimate inner loneliness. This loneliness can be experienced as a depressive and irretrievable loss.

Klein (1963) too acknowledged the importance of a good internalised mother figure (highlighted in an earlier section by Winnicott) who creates a relative security in her infant's mind. This kind of internalisation of a relationship between mother and her infant is at the core of helping the child's

ego to develop an increasing capacity to master uncomfortable feelings in a phase-appropriate way. The integration takes place step by step, but full and permanent ego integration may never be possible to achieve. We would have temporary experiences of 'oceanic' feelings when regressing in the service of ego, like in artistic or orgasmic experiences. As adults, we can never reach such a state in which we are perfectly soothed and responded to, not by ourselves or by anyone else. By using an active defensive process, some of our emotions, phantasies and anxieties will be kept unconscious to us and some of our 'unwanted' qualities will be projected into other people. In this way our unconscious helps us to manage those kinds of current problems which are too difficult for us to face. The longing to totally understand ourselves is bound up with our need to be understood by the internalised 'good mother' in our minds. One expression of this longing, and very typical for children, is the universal phantasy of having a twin somewhere. The twin then represents those uncomprehended and split-off parts of the individual, which she is longing to find a home for. There is a hope to achieve wholeness and complete understanding of oneself. The 'phantasy twin' is the ideal benefactor who totally understands the child and provides perfectly.

Similarly, Winnicott (1988) also discussed isolated and unknown parts of our 'self'; those parts in our mind that we are unable to share fully with others and which are unknown even to ourselves. These unknown parts of ourselves need to be differentiated from those more known parts of ourselves that cannot fully be known by others. Satran (1978) stated that showing empathy to someone who is lonely, is often difficult because the private worries the person is ruminating in her solitary state, may remain not sufficiently expressed. Almost all my research patients felt often emotionally lonely with their husbands but in this connection, I questioned whether it may have been sometimes also the patients' own difficulty to express their inner thoughts clearly enough. Naturally, different people attempt to relieve their loneliness in various ways (Rubins, 1964). One way is to ask for help via our body, by presenting different kinds of pains and ailments, like for example 'B', 'G', 'K' and 'M' were doing. In relation to this point I have previously referred to Schoenberg (2007) who has seen the significance to understand a somatic patient's unconscious communications via her body. I have also cited McDougall (1989) who has discussed patients who express their emotions through their bodies; in a similar way as they did before, that is in their infancy. Pines (2010) regarded this as a woman's unconscious way to avoid psychic conflicts through expressing them in her body. The lonely unsatisfied person may also fill her inner emptiness, at least temporarily, by finding another person and in this way will continue living through the other. 'A' tried to fill her loneliness in that way; she was continuously looking for answers to her uncertainties from others and wishing that they could sort out her problems instead of trying to contain them by herself. We can use different defences against inner loneliness; excessive dependency, independency or denial of loneliness may diminish it and be helpful for a while, but these approaches will never totally eliminate it. Robinson (2018), referring to Winnicott, has noted that we can never be fully known by another person

(meaning people in general), no matter how intimate our relationship is with that person. We must confront our incompleteness and recognise that, ultimately, there is a core in all of us which we, even ourselves, do not know. In that sense we are all eventually on our own. This is the basic inner loneliness in all of us and we have to find ways to manage it.

5.3.4. The ‘Good Internalised Mother’ Looking After Our Bodies

Psychoanalytic theory sees the importance of the ‘good internalised mother’ in our everyday life, and more importantly, in situations where we are struggling. Winnicott (1965a; 1975) highlighted that the ‘ordinary’ mother’s loving care will give the foundations of psychological health for her baby. Mother’s ‘holding’ her baby in different kinds of repetitive physical ways, such as bathing, feeding and changing, helps the baby gradually to experience that her own body is the place where she can securely live. These kinds of recurring physical experiences strengthen the baby’s feeling that her ‘being’ in the world will be continuous. And that is the foundation for the future development of ‘self’ feeling; the feeling ‘who we are’ is a central factor for any subjective experience in later life. Hence, our ‘self’ feeling has its origins in our body. In the later interviews, quite a few patients, like ‘A’, ‘F’ and ‘J’ for example, were visibly looking after their bodies much better when they were re-finding their ‘good internalised mothers’. I have previously referred to Solms (1995) who has suggested that our earliest sense of safety was reflected in the feeling of security we acquired as our mother met the physical needs of our body. I would see this attachment serving as a security measure in response to feelings originating from our body that we are met. As adults we tend to have an inner sense of functioning like our mothers did with us, as if we had an internalised mother figure in our minds looking after our bodies.

5.3.5. The Threat of Physical Illness

A potentially life-threatening physical illness is a potential terror for all of us and in that kind of situation we need to find our good enough internalised ‘mother figure’ in our minds (that is the person who has primarily looked after us; either the mother or mother substitute). Here we are reminded by Winnicott’s (1988) words that normally, in health, the mind and body go together, a person’s ‘self’ is her body. But an illness can be a threat to our continuity of ‘being’, reflecting the very early fears of losing a cohesive or coherent ‘sense of self’, which can be experienced as disintegration. As I have earlier referred to Kaplan-Solms and Solms (2000), there are also fears linked with later sources, such as conflictual feelings towards our bodies. Our love for our body gives us a phantasy that it is under our omnipotent control, whereas at the same time we feel hatred towards our body when it is disturbing or distressing us with different demands. However, most illnesses do not lead to major

threats to our existence; but in contrast, a potentially life-threatening illness such as cancer, will, for many people, stir up anxieties about suffering during dying or death. Related to this, there will be a fear of the cancer returning, once in remission; and this was the situation also for many of my research patients when they were worried about their future. It is a matter of psychoanalytic interest whether humans fear death as a definite absence, or whether the death is seen more commonly as some other form of existence as in religious thinking.

Using Winnicott's ideas that a person's 'self' feeling comes to a great deal in early life from her body, we can understand that when a person is faced with a serious potentially life-threatening physical illness, her 'self' cannot feel safe now. The mind has at least temporarily disconnected itself from the potential realities of the sick body and the person can't trust any more in her body which is now out of control and not a safe place to live in. In religion for example, the reality of the sick body that might not exist or will disintegrate, is often not conceivable. So, the ideas of an eternal life may comfort some in the face of fearing 'death'; and this was the case with 'D' who was not at all frightened of death because she was going to go to 'a better place'. This creates the idea of everlasting life, a perfect union. Freud (1957 [1915]) has claimed that our unconscious does not acknowledge death because we do not have any experiences of that. Also, Martindale (2007) has written about everlasting life and fear of death which for some people means going on 'living' in a persecuted state (not resting in peace) after passing away.

Many research patients described how insecure and lonely they felt with their bodies now. They were frightened of never recovering from their illness and being left to suffer endlessly on their own. The loss and loneliness were hand in hand here as the loss of security in the 'old' body and the fear of death were closely linked with being forever alone. This fear will remind us of a very early 'annihilation' anxiety, term used by Winnicott (1974, [1963]), which the baby will feel if she is left too long on her own. This kind of unthinkable anxiety is linked with threats of psychic survival and fears of breakdown.

Some patients, like 'A', 'F' and 'K', had memories of 'horror' pictures where their close family members were dying of cancer. A few others, like 'D' and 'G', had ideas of cancer being contagious and even the word 'cancer' was frightening for some of the partners to articulate; instead, they preferred to use the word 'it' or 'the thing'. This phenomenon can be seen linked with magical thinking where the words are feared to have a power to make things happen. These kinds of thoughts added to the patients' feelings of being lonely and frightened of their future. Physical intrusions into one's body, as happens in various treatment procedures, may also provoke some earlier bodily traumas which don't necessarily always have any clear conscious memories. This kind of situation happened with 'L' who experienced some of her medical procedures as an abusive attack against her body.

These current hospital experiences had symbolic links with some earlier memories and struggles in her life. And 'L' was able to make some of these connections by herself. I wonder whether 'L' had ever had any 'proper' chance to talk through her difficult past experiences with her 'violent' parents and her 'abuser'.

Physical illness, when the patient is distressed and uncertain what will happen to her, will evoke the inner loneliness and the 'childlike' longing to obtain a perfect attunement from another person, just without words. There are also wishes to be taken over by another person, a parent-like figure, and pass all the responsibility to him or her. We can see that this kind of childlike attitude is a regression and defence against taking a responsibility for one's own life. I questioned whether there had been, in the person's life, a disparity between having these unconscious images of an idealistic response from another person and the less than perfect earlier response in reality that would have created her loneliness. Perhaps the discrepancy was one important element here as it was interesting to see that nearly all patients felt that there was no emotional support coming from their husbands. The emotional loneliness was striking in almost all patients even though many of them had husbands and several extended family members around, trying to be helpful and supportive. Other people's efforts were doomed to fail in the patients' mind if they were looking for total understanding; something that is not possible for any of us as adults. This was the situation, for example, with 'A' and 'B' who felt they were left totally on their own even though there were many helpful people around. Several patients, for example 'C', 'D', 'G' and 'M', felt that they needed to look after other people, their family members, so that these people did not become upset. It was often easier to project one's own neediness into the other people than to acknowledge it in oneself. There was often no space for the patients' innermost feelings, and they were more in touch with these when left to their own devices, like for example at night-time. This was poignantly described by 'M' who could not cry because her husband started to cry or by 'G' who had to cry in silence during the night and be aware that she did not wake up her sleeping husband.

I am questioning whether in this kind of crisis situation, regardless of how good-enough the internalised childhood figures may have been, all patients will temporarily lose touch with these 'internal' supports. As I have already mentioned in the 'Results' section, in relation to Winnicott's (1960) 'holding mother' and Rey's (2001) 'brick mother', the hospital staff may become 'in loco parentis' for some patients in the most distressing phase of their illness. And when all the treatments have been completed, the ending could be experienced as an abandonment by these 'parent' substitutes. This kind of situation was described by 'A' and 'G' who were both dreading their future without the Breast Unit connection. Different people manage their inner loneliness in various ways, but most individuals will find an inner trust to assume that their life will continue, after they have recovered from their treatments. My observation was that gradually quite a few patients got in touch

again with their internal strengths and were able to manage their loneliness step by step without feeling alone or abandoned. However, I suspect that those patients who were left struggling and who found it difficult to move on in their lives, were the ones who may have had difficulties in re-establishing their 'good enough internalised figures' to look after them. If these patients had not been helped in the past as young children to manage their emotional loneliness, they would have struggled in their present-day stressful situation. It is important to note here that several patients had had some psychological problems in the past and three had needed psychiatric medication. If we have not been able to internalise a good helpful figure into our minds, parts of ourselves may have become even more inaccessible for us increasing the feeling of inner loneliness.

5.3.6. Basic Inner Loneliness

Mourning is very much, not only mourning of having actually lost people close to us, but also coming to terms with the inevitable fact that we neither knew completely the lost person, living or dead, nor knowing completely ourselves, no matter how long we live (Robinson, 2018). I think here loss and loneliness come again together. The losses leave us feeling lonely, but the losses will also touch that ultimate inner loneliness in all of us.

The results of my study strongly suggest that the loss of breast or parts of it, will provoke powerful distress bringing alive many previous losses which may not have been worked through in the past and thus have left the person with some psychological vulnerabilities. The losses will also evoke that basic ubiquitous loneliness which we need to manage with the help of those resources we have achieved during our lives. Of course, people are very different in their responses and in the intensity of their distress, but this subject can be better understood if the life history of the person and how she has managed previous losses in her life, has been taken into account. Understanding the person's life history to loss can provide indications as to what might be the most useful ways to help this particular individual to manage her present-day illness and its psychology. Pines' (2010) words will remind us that 'past cannot be erased, but a more mature understanding of oneself may help to replace difficult feelings with compassion. This can enable the person to seize the opportunity for a new beginning and a greater pleasure in living.'

5.4. Links Between my Findings and Previous Non-Psychoanalytic Research

As I have already mentioned in the 'Literature Review' section, it was surprising to realise that hardly any psychoanalytic research on breast cancer has been carried out, even though the breast plays

such an important part in psychoanalytic theory. My approach is therefore unique, as my thesis provides a psychoanalytic understanding of the matters related to the breast. However, my findings are consistent with findings of other similar disciplines. In the following I will give some examples of these findings from non-psychoanalytic studies (which I have already referred to in the 'Literature Review' section).

The powerful distress which my research patients experienced after being diagnosed, and yet 'not knowing' the full extent of their illness, the treatments and implications for their future lives, had already been recognised in earlier research. For example, Lönnqvist et al. (1981) and Achte et al. (1981) discussed breast cancer being a major crisis, a serious threat to the person's biological and psychological existence, to her 'self', to her whole identity and sense of security. Many other studies have shown high levels of psychological distress (Postone, 1998; Bleiker et al., 2000). Moreover, both helplessness and hopelessness as personality traits have been recognised as risk factors for not managing the crisis (Campos et al., 2012). Rodgers and Humphris (2013) summarised their findings that the highest ranked concern of breast cancer patients was the fear of their cancer returning. According to Goldie (2005), breast cancer patients often feel worse after treatments, especially, if they have felt, prior to diagnosis, generally healthy without any symptoms, which was the case with most of my research patients. A study by Costanzo et al. (2007) found heightened distress and disrupted adjustment after completion of treatments and being discharged, similarly to some of my research patients.

Emotional loneliness was felt as so distressing by almost all my research patients. The psychological value of support has been recognised by many previous authors. Lack of psychological 'holding', as a form of marital distress, was acknowledged by Young and Schuler (2009). Many other authors have recognised the long-term psychological morbidity that was often associated with a lack of support and with previous stressful life experiences (Parle, Jones & Maguire, 1996; Bleiker et al., 2000; Fallowfield, 2002; Burgess et al., 2005; Campos et al., 2012). Golden-Kreutz et al. (2005) suggested that the amount of initial stress linked with the illness of breast cancer was to predict both psychological and physical quality of life in later stages after recovery. Furthermore, O'Connor et al. (2011) highlighted the lack of a 'good enough' supportive environment, that is a low (social) status, poor physical and mental health and low-level physical functioning, as being risk factors for post-traumatic stress symptoms. Some other authors have indicated that higher levels of social support were associated with better quality of life (McArdle et al., 1996, Kwan et al., 2010 and Waters et al., 2012). In this way all these authors regarded the emotional loneliness as a risk factor if the patients were left without adequate support systems, the 'holding environment'.

Some studies have indicated, in an indirect way, that the distress may be linked with some other factors in a woman's life. Lipowski (1981) had already previously suggested that gross psychological reactions may bear little or no relation to the objective severity of the current physical illness or its treatments. Fallowfield (2002) reported high psychological morbidity amongst all women with breast cancer, irrespective of the extent of their surgical procedures. And similarly, Burgess et al. (2005) found that the psychological problems with breast cancer patients were not associated, at any time, with clinical factors (the nature and extent of their illness).

The experience of previous losses which were so prominently present amongst my research patients, has been recognised, again indirectly, by some authors. Both Fagundes et al. (2012) and Janusek et al. (2013) discussed the links between difficult childhood experiences and greater distress in an individual's capacity to manage her illness of breast cancer in later life. Both studies suggested that there must be a way of understanding the dynamic or the connection. Perhaps these different kinds of disturbing previous experiences had not been adequately psychologically processed in the past, and the difficulty in managing them may be provoked in the current crisis situation of a threatening physical illness. These findings have gradually led to requests that the patient's whole life history should be recognised. Pattison (1974), for example, had already much earlier indicated that the illness may release previously repressed emotions and unresolved conflicts. Later Daune (1995) highlighted that the woman's psychological history should be taken into account every time breast cancer is diagnosed because 'her psychic scene is invaded by her sick body'.

All these studies helped me to find my own research question; namely that if it was not the severity of physical illness or the extent of its treatments, then there must be other underlying, less obvious factors in a woman's mind, determining the level of her psychological distress and her ability to adapt to the new situation. I found that these factors were emotional loneliness and different kinds of previous losses, often connected with each other, which had such a powerful presence in my study.

5.5. Summary of Theory

Using a psychoanalytic approach, I have explained how a woman's seemingly excessive distress (in that it cannot be explained just by her current situation regarding the type and prognosis of her breast cancer), has links with her life history. Some non-psychoanalytic studies had suggested links with more obvious adverse life-experiences but had not elaborated these connections any further. My study concentrated on these experiences, but on a deeper psychological level, as I linked these issues with underlying, less conscious reasons for the distress.

I found that the loss of breast (or a part of it) evoked memories of previous unresolved traumatic losses and distressing loneliness in these women. Psychoanalysis understands that traumatic losses will stay traumatic if they are not mourned over time and they will become alive again in a current situation of loss. If the person has not been helped as a child to mourn her losses, she cannot trust in help in her later life as she had not had experience of it. The person cannot readily 'use' people around her and this exacerbates her inner loneliness. There is a life-long wish in all of us to be totally understood without words, just as we wished for in our childhood. However, this kind of experience is not possible any more for us as adults. If these women were looking for this kind of total attunement, the others' efforts to help them were doomed to fail.

In health our 'self' (the feeling who we are) is experienced in our bodies. A serious physical illness threatens to disintegrate this close body & mind relationship opening the door for overwhelming anxieties. Being diagnosed with breast cancer and having to go through its treatments will normally be a major shock for most women who may at least temporarily regress and resume their earlier ways of avoiding trauma, such as using denial or else being overwhelmed by anxiety when the reality of breast cancer is just too much to face. They lose from their minds their 'good enough' internalised helpful figures. Breast cancer is an external danger and understandably provokes anxieties in a woman's mind. Nevertheless, this external danger will also provoke anxieties coming from within, from internal dangers in our minds. These internal dangers are often linked with different kinds of unresolved losses, such as losing one's love object, losing the object's love or losing the 'holding environment'. These past traumas will become now alive again. Panic is by definition a terror, an anxiety state with a fear of not surviving. The women who I interviewed, temporarily lost their 'holding maternal environment' subsequent to their diagnosis and some others felt abandoned by the Breast Unit after their treatments had ended. Some women were looking for a 'total cure', searching for eternal life where their mortality was denied. In recovery many women were able gradually to re-find their helpful containing parental images, close the door to the overwhelming anxieties and leave their traumatic experiences in the background. However, some were left struggling alone without this kind of internalised support.

In this way psychoanalytic theory helped me to understand that this seemingly disproportionate distress in some women's current situation in fact was not at all disproportionate considering that the distress was provoked by memories of their unresolved traumatic losses and experiences of not having had 'good enough' parental figures in their minds. Having had these kind of internalised figures would have helped them now to manage better their current traumatic situation of breast cancer and their loneliness.

6. CONCLUDING REMARKS

6.1. My Journey

In autumn 2013 I started to plan my psychoanalytic study about women's psychological experiences with breast cancer diagnosis and its treatments. In my profession, when working both as a psychoanalyst and clinical psychologist, I already had some understanding, from listening to my patients' experiences in therapeutic situations as to how breast cancer can have a powerful impact not only on the patients themselves, but on their whole families. It had been the Breast Unit's observation that the psychological distress amongst their patients had little or no relationship with the stage or prognosis of their illness. This realisation provoked my interest to explore that if it was not the severity of physical illness or treatments which determined the level of this distress, then, what were those other less obvious, underlying factors in a woman's life that were linked with her distress.

I spent considerable time on my 'Literature Review' going through numerous studies on breast cancer and its psychological impacts on women's life. As I have already highlighted in the literature section, these studies clearly acknowledged the major distress that this illness causes. However, even though we know that the treatment of breast cancer is a long-term process, which usually lasts several months, I was surprised to find out that there was a lack of longitudinal research carried out in this area. Mainly, many of the studies offered a kind of 'snapshot' approach which only concentrated on a specific stage of the illness or treatment or some personality traits. They failed to investigate whether there were any additional underlying issues in a woman's life that her distress may have been linked with. It was quite clear to me that the patient's unique life experiences were not considered. I also noticed that in the field of psychoanalysis, my own theoretical approach, where the meaning of breast is so crucial, there was hardly any research done in the psychology of patients with breast cancer, with the exception of some case studies. I regard my study as filling this gap in research and being novel in a sense that I have 'followed' the patients through their treatment process and approached this subject from a psychoanalytic viewpoint. The longitudinal design created a 'safe' setting, a 'holding' environment for the patients. This arrangement encouraged them to open up about issues from their lives which they most probably would not have raised during a single interview. For me to be able to carry out this type of research, was facilitated by my special professional skills which, in Kvale's (2003) words, could not be simply transferred from one researcher to another.

In this study, I have used a psychoanalytic research method to understand less obvious underlying reasons which may have increased the women's distress. In order to have a chance of grasping underlying issues of different kinds, I needed a longitudinal study where I could listen to each woman carefully. Therefore, I arranged four individual interviews with every patient to follow her during the illness process. As I have clearly highlighted in the 'Methodology' section, seeing each patient only four times was not 'psychoanalysis' or 'psychotherapy'. That kind of treatment is carried out during a longer period of time in a stable and regular setting where the hypotheses can be tested further. The interview sessions, however, certainly had therapeutic value for the patients. They felt relieved after having had the opportunity to talk about difficult issues in their lives which were provoked by the experience of their illness. I want to emphasise here once more that my conclusions cannot be absolutely definitive, as I only saw these patients for a very limited amount of time. Nevertheless, and I am confident here, my suggestions and conclusions have a firm basis as they are linked with my theoretical knowledge and clinical experience.

My hypothesis that the psychological distress was linked, not only to the physical illness itself, but some other less obvious, underlying factors in the women's past which were now evoked by their illness, proved to be correct. The evidence in my study, interpreted using psychoanalytic theory, has shed light on these issues and suggested these links. The most striking features that I found were the impact of different types of losses from the past on the current emotional state, as well as emotional loneliness. My study will strongly support the more contemporary ideas of the importance of a psycho-oncological approach, where the 'whole' patient is treated for her physical illness. In connection with this I have previously referred to Daune (1995); Dolbeault, Szporn and Holland (1999); Schoenberg (2007); and Gorini et al. (2015) whose approach has become so obvious to me after having interviewed these ten patients, the majority of whom had their breast cancer detected in a routine mammogram. Most of the women had no inkling that there was a potentially life-threatening physical illness inhabiting in their body which they had previously believed, to be healthy. This kind of totally unexpected 'bad' news was bound to create a powerful psychological crisis reaction in all these women's minds. However, as my results indicated, other 'unresolved' or 'critical' issues from their past were also evoked and spontaneously talked about. These other issues clearly seemed to be a major determinant of their personal distress.

The limitation of my study has been that it is of a homogenous group as all participants were older (of a certain age group), white and local women even though the interviews were open for all women over the age of twenty who could express themselves in English. Nevertheless, these research patients represented a typical patient population of the Breast Unit, as shown in the table of 'Demographic Information Collected from the Questionnaires' in the beginning of the 'Results' section. Two younger patients interrupted their participation after the first interview which, I

speculated, was because facing the reality of breast cancer may have been too painful for them. In general, younger women are more likely to have more aggressive breast cancer, as they are less likely to have oestrogen sensitive illness. However, younger women do tolerate more powerful forms of treatment better than older women, so they may not necessarily fare any worse. Nevertheless, the psychological impact of diagnosis and treatment can be significant for younger women, creating great uncertainties about living a long life and the devastating consequences of possible early menopause. I hypothesised that there may have been more unconscious reasons for the older women to participate; their need to bring up the earlier losses, many of which had not been worked through in their minds but had now been evoked by their present illness.

6.2. Suggestions

My research supports recommendations that when breast cancer is diagnosed, and a woman seems to be particularly distressed, then the important aspects of her life history should be taken into account. Ideally, the person doing this would be a professional who is an expert in understanding possible underlying issues for current distress; an expertise that stems from a psychoanalytic training. Having a team member with such expertise available to the staff group could also offer other team members the opportunity to improve their understanding of the issues that lead to distress in some patients. It was noticeable that many of the patients I interviewed, had suffered from some previous psychological problems and a few had needed medication. Certainly, it can be useful to apply various psychological strategies to an individual as to how to manage her distress. However, I firmly believe that even more important for most people is to be listened to and so to assist them to recognise and understand the sources of their distress by themselves. During the course of four interviews I was able to form a clear picture of each individual patient and for that reason, I did not have to use any specific psychological 'survival' techniques or provide any quick fix solutions for their problems. My most important 'tool' was to offer myself to listen to the patients in a 'quality' way, to be a 'container' for them to feel 'contained' with their distress. It was this process by which the patients were able to talk, be listened to, and be 'taken in', that had the most therapeutic value in this practice. Through the processes described in previous sections and summarised here, I can confidently say that 'free' talking about difficult thoughts and feelings, possibly for the first time in these women's life, and making connections between their feelings and past experiences, will usually help in reducing this kind of distress.

The most significant outcome of my research is its demonstration that these women with newly diagnosed breast cancer and its subsequent treatments experience distressing amounts of emotional loneliness and their minds are also preoccupied by memories of many previous losses

evoked by their illness. Furthermore, my research has led to recommendations for therapeutic interviews where the issues linked with losses and loneliness could be talked over. Winnicott (1965b) saw that even single consultations could be therapeutic in a variety of situations. These consultations are based on an analytically trained mind listening to unconscious communications, especially what is said 'between the lines' and 'what is not said', by the patient seeking help. 'Applied psychoanalysis' in the form of brief psychoanalytic interventions, has been also discussed by Borden (1999). The author pointed out the need to develop more flexible and realistic approaches which will broaden the base of short-term dynamic therapeutic encounters, suitable for example in a busy hospital setting.

Further psychoanalytic research could also be carried out on the early relationships in patients' childhood to learn whether the findings might offer additional indicators to identify those women who are at risk for more longstanding psychological problems when faced with an illness of breast cancer. A more practical approach, based on the outcome of my work, could be to offer those patients with excessive psychological distress (considering the stage and prognosis of their illness), a short questionnaire which will cover the risk factors recognised in my study. As the emotional loneliness felt by nearly all patients was so alarming, it would be essential to enquire of the availability of support for the patient beyond the Breast Unit, such as support coming from her partner, children, extended family members or friends. Considering that the loss of breast, or parts of it, evoked so many memories of previous losses, it would be also necessary to enquire these further; such as the patient's own illnesses and those of other important persons, deaths and other losses. This background information, gathered from the proposed questionnaire, could then be used as a 'scaffolding', a 'holding' environment where the staff members, for example the breast care nurses, could listen to and understand their distressed patients. In a discussion group led by a professional who is familiar with psychoanalytic theory, the staff members could be helped to develop their 'listening skills' without having to feel that they need to provide just 'standard' responses to their patients' problems.

To end, I will recommend some ideas as to how to help patients who are particularly distressed. It is important that the patient's life history should be taken account, and this could happen in the following ways.

1. The patients could be offered a short questionnaire to draw out those who have higher risk factors (especially losses and loneliness recognised by this study). This background information will be then used as a 'supporting environment' for staff members to listen and understand the distressed patient.

2. A discussion group led by a psychoanalytically trained professional could offer an opportunity for staff members to further develop their 'listening skills'.
3. Some patients could be offered therapeutic consultations (even single ones) by a psychoanalytically trained professional.

A psychoanalytically orientated help, the so-called 'applied psychoanalysis', which will recognise the less obvious, underlying issues of breast cancer patients' distress, could well offer an opportunity to understand the personal meaning of the illness and its treatments. This approach has a potential to help individuals not only to see themselves as defined just by their illness, as 'breast cancer survivors', but for them to be able to mourn the impact of their past losses at the present time and manage their 'inner' loneliness; in this way they will be offered to make the most of their lives like many others do.

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9. APPENDICES

Appendix no 1: NRES Letter

16th November 2015

Mrs Mäkinen-Martindale Private Practitioner
5 Tynemouth Terrace
Tynemouth
Tyne and Wear
NE30 4BH

Dear Mrs Mäkinen-Martindale

Study title:	A Psychoanalytic Study of Women's Experience of the Diagnosis of Breast Cancer and Subsequent Treatments
REC reference:	15/NE/0273
IRAS project ID:	159152

Thank you for your letter of 12 November 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, xxxx

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a **Favourable** ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

15/NE/0273 Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

A handwritten signature in black ink, appearing to be 'Mb'.

Professor xxxx
Chair

Appendix no 2: Staff Information Sheet

WOMEN'S EXPERIENCE OF THE DIAGNOSIS OF BREAST CANCER AND SUBSEQUENT TREATMENTS

SUITABLE PATIENTS FOR THE STUDY:

Over 20 years old
EXPERIENCING ANXIETY
WILLING TO TALK ABOUT THEIR EXPERIENCES
Primary breast cancer detected
Waiting for the breast operation
(Important: first interview has to happen BEFORE the operation)
The operation will be followed by radio- and/or chemotherapy

If the patient shows interest in taking part in the study, give her the PATIENT INFORMATION SHEET. Tell the patient that if she wants to participate, she needs to contact me DIRECTLY within a few days and definitely well BEFORE her operation.

My contact details are in the patient information sheet.

NOT SUITABLE PATIENTS:

Patients with clearly detectable mental health problems or addictions
Patients who can't express themselves adequately in English

If YOU want to contact me:

Merja Martindale
Mobile:
Land line:
Email:

Appendix no 3:

Patient Information Sheet

Version 8, 28.10.15

PATIENT INFORMATION SHEET

My name is **Merja Martindale** and I am doing a study about **WOMEN'S EXPERIENCE OF THE DIAGNOSIS OF BREAST CANCER AND SUBSEQUENT TREATMENTS** as my Professional Doctorate research topic at Northumbria University. The University has approved this study. I am a clinical psychologist and psychoanalyst, but it is not my intention to undertake any psychological treatment as part of my research. I would like to invite you to take part in my study which will happen here in xxxx. Before you decide anything, it is important for you to understand why this research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with your family members or friends if you wish. Ask me if there is anything that is not clear or if you would like more information. Allow yourself time to decide whether or not you wish to take part. However, it is important, due to the nature of my study that **you make up your mind within a few days and well before your breast operation.**

For any further information and to let me know of your decision, **please contact me directly by phone on xxxx** (leave your name and contact number on my answer phone if I am not available) or **by email on xxxx**

The purpose of the study

A newly detected breast cancer with all its subsequent treatments is not only gruelling for a woman's body but creates lots of distresses and worries in her mind. The purpose of this study is to explore what goes on in breast cancer patients' minds when they are trying to cope with their distress, perhaps during one of the most difficult times of their life. The aim is also to find out whether there are any specific factors which will determine the level of this distress. At present this distress is not often recognized enough and not attended to sufficiently in the NHS.

An important feature of this study is that it follows a patient all the way through her treatment and concentrates on her individual experience of it. As the treatment of breast cancer is usually a long-term process, the study can last for 8-9 months.

The choice of the patients

You have been chosen to this study because you have got a newly detected breast cancer and you will have breast surgery as your first treatment. The total number of participants for this study will be ten women.

Taking part in the study

It is totally up to you to decide whether or not to take part. If you decide to do so, you will be given this information sheet to keep and you will be asked to sign a consent form. A copy of your consent form is given to you. If you decide to take part, you are still free to withdraw at any time and without giving any reason. Your choice whether to participate or not in this study will not have any effect on the standard of care you receive or your legal rights. I will assure you that your breast cancer treatment will not be affected in any way nor will your access to further trials and research. If you decide to take part in this study, a standard letter informing about your participation will be sent to your GP.

What happens to you if you take part

You will be involved in the study for as long as your various cancer treatments continue. The maximum time will be 8-9 months. I will meet with you five times in total in the course of your treatment process.

If you decided to take part in this study, **you should contact me directly** to organise a suitable time to come to see me at the hospital. We will have an **initial meeting** together where I will go through

this information sheet with you. Then you can ask from me any questions you might have regarding this study. I will then ask you to sign a **consent form**. After you have signed the consent form and agreed to participate in this study, I will give you a short **questionnaire** about your life in general. You can fill it at home and send it directly to me in a prepaid envelope. This first initial meeting will take about 30-40 minutes.

After our initial meeting I will offer you **four interviews**, each of which will last up to 60 minutes. These interviews will take place at the hospital. I will try to organise them for the same time when you have another appointment there. Sometimes this is not possible, and you need to come for your interview at the hospital in a different time. In that case, your travelling expenses will be funded. Your first interview will happen soon after our initial meeting. Your second interview will be after your operation and you having heard the findings of it. Your third interview will happen sometimes during the course of your other treatments which might include chemo-and/or radiotherapy. Your fourth interview which is the last one, will be after all your treatments have been completed. In these interviews you are encouraged to talk about all the thoughts and feelings which your experiences with breast cancer and its treatments have provoked in you.

The possible disadvantages and risks of taking part

As we are talking about a very stressful time of your life, it is fully understandable that you might become upset as a result of that. However, I will be there sharing these worries with you and giving you support.

The possible benefits of taking part

These interviews are intended to give you a meaningful and important experience, helping you to understand yourself and all the feelings which have been provoked by your illness. There are not necessarily any immediate benefits to anybody in participating in this study though we hope that the benefits will be in the longer term if this research leads to recommendations for a particular kind of psychological service.

Confidentiality

Our discussions during the four interviews will be audio-recorded. The reason for this is to help me to collect all material accurately. The anonymised recordings will be then transcribed by a professional transcription service under a strict confidentiality agreement. All the information which

is collected about you during the interviews and from the questionnaire will be kept **strictly confidential**. It will be stored securely at the hospital and destroyed in 6 months after the whole research project has ended. This information is only accessible to me and it will be used only for this study. Bits of the interviews may be made part of the final research report but **under no circumstances will your name or any other identifying characteristics about you, be included in this report**.

If you become very distressed and find it difficult to cope, I may notify, with your permission, the breast cancer team members about this, so that you could be provided with extra support. However, I will not inform them about the confidential issues you have told me unless they are seriously threatening your wellbeing.

Not wanting to carry on with the study

If you find the interviews too difficult, we may consider stopping your involvement in the study. If you decide to withdraw from the study, you are entitled to do that at any time. In that case, you can choose to have the data collected from you to be either retained by me and allow me to use that information in my study or it to be destroyed.

Complaints

If you have any concern about any aspect of this study, you should speak directly to me and I will do my best to answer all your questions (phone xxxx or email xxxx). If you don't find our discussions helpful, you may wish to contact **Patient Advice and Liaison Service (PALS)** who will give you confidential advice, support and information. They can be contacted on **Freephone 0800 032 0202**. If you still remain unhappy after your discussion with PALS, they will help you to make a referral to **Patient Relations Department** who will coordinate the further investigation of your complaint. Information about how to access independent assistance to support you through this process, can be also provided by **Independent Complaints Advocacy Service (ICAS)** on **Freephone 0808 802 3000**.

Review of the study

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by NRES Committee North East – xxxx.

Appendix no 4: Letter to GP

Date

Dr XX

Surgery Address

Dear Dr XX,

We are writing to inform you that your patient **Mrs X, date of birth & address** has volunteered to participate in "A psychoanalytic study of women's experience of the diagnosis of breast cancer and subsequent treatments". This study will be the basis of a professional Doctorate through the Northumbria University.

The study will be conducted at the Breast Unit at the xxxx. The patient will be offered four individual interview sessions at different stages through her treatment journey. Although the interviews will focus primarily on issues connected with her treatment experiences, she will be encouraged to speak freely about her global life experiences in order to identify factors which may determine her particular level of distress. The individual participant will at all times remain in control and will not be coerced into discussing matters she finds too distressing.

The interviews will be conducted by the chief investigator Merja Makinen-Martindale.

Merja Makinen-Martindale

xxxx

Psychoanalyst

Consultant Oncoplastic Breast Surgeon

Clinical Psychologist

Email xxxx

Email xxxx

Phone xxxx

Appendix 5: Consent Form

Version 7, 28.10.15

Study number: R&D 7502

Patient identification number:

CONSENT FORM

Title of project:

A PSYCHOANALYTIC STUDY OF WOMEN'S EXPERIENCE OF THE DIAGNOSIS OF BREAST CANCER AND SUBSEQUENT TREATMENTS

Name of researcher: Merja Martindale

Please initial box

1. I confirm that I have read and understood the PATIENT INFORMATION SHEET (Version 8, 28.10.15) for the above study. I have had the opportunity to ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation in this study is entirely voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care, legal rights or my access to further trials and research being affected. ☐
3. I understand that my GP will be informed about my participation. ☐
4. I understand that my four interviews will be audio-recorded and afterwards transcribed by a third party but my all personal identifiable information will be removed. ☐
5. I understand that bits of these interviews may be made a part of the final research report but under no circumstances will my name or any other identifying characteristics about me, be included in this report. ☐
6. Should I become distressed at any point during the interviews, I agree that you may contact breast cancer team members who will provide me with extra support. The confidential issues about me are not discussed with the team unless they are seriously threatening my wellbeing. ☐
7. I agree to take part in the above study. ☐

Please send me a report on the results of this study (circle one): Yes No

_____ Name of patient	_____ Date	_____ Signature
--------------------------	---------------	--------------------

_____ Researcher	_____ Date	_____ Signature
---------------------	---------------	--------------------

1 copy for patient; 1 copy for researcher; 1 copy to be kept with hospital notes

Appendix no 6: Questionnaire

Participant code: _____

QUESTIONNAIRE ABOUT YOUR LIFE

CONFIDENTIAL DOCUMENT

It would be helpful, alongside your interviews, if you can give me some information about your life in general which will then give me an even more inclusive picture about yourself. I would appreciate if you would take some time and fill in this questionnaire at home and then post it to me in the pre-paid envelope provided.

This is a **strictly confidential** document where you don't need to give any names and your anonymity will be guaranteed. The document will be used only by myself for the purposes of this research and will be destroyed at the end of it.

Answering this questionnaire is totally voluntary. There are some sensitive questions you might find upsetting. You don't have to answer any questions if you do not wish to.

Thank you,

Merja Martindale

ABOUT YOUR FAMILY HISTORY

It would be helpful for me to have some information about your own childhood family. Please could you give me the following information.

Details about your **parents**:

	Age now or at death	If deceased, please give the date	Occupation
Father			
Mother			
Stepfather (if relevant)			
Stepmother (if relevant)			

Details of your **brothers, sisters and yourself** in order of age
(Please include any still births & miscarriages):

Brother/ Sister/ Yourself	Age now	If deceased, please give the date	Marital status	Occupation

Please could you tell me something about your **mother**, her personality and your relationship with her.

Please could you now tell me something about your **father**, his personality and your relationship with him.

ABOUT YOUR PERSONAL BACKGROUND

It would be helpful if you can tell me something about your **infancy, childhood** and **adolescence**, including any changes or separations that you experienced. Were there any relationships especially important to you?

ABOUT YOUR EDUCATION AND EMPLOYMENT

Please could you give me a brief summary of your **education**.

Please could you give me a brief summary of your **previous employment**.

Please could you give me some brief details about your present **occupation**. Or if you are **retired**, please describe how you spend your days.

ABOUT YOUR CURRENT MARITAL STATUS AND DOMESTIC LIFE

Please tick in box:

Single	
Married	
Living with a partner	
Divorced	
Widowed	

If you are married or living with a partner, please state:

For how long	
Age of partner	
His/her occupation	

Please could you list your **children** (including stepchildren) in order of age (eldest first). Please also indicate any stillborn children, miscarriages or termination of pregnancy. Please also indicate if any of your children have been adopted.

Daughter/son	The age now or at time of death	If any of your children have died, please indicate your age when this happened

Please could you describe me your **relationship with your children**.

ABOUT YOUR RELATIONSHIPS

Please could you tell me about your **family life**.

Please could you comment on the quality of your **sexual life**.

ABOUT YOUR HEALTH

Please tell me about your **physical health** in general. Except your breast cancer, have you had any other serious illnesses or operations?

How do you feel in general about your **body**, the way it functions, how it looks? Do you feel “at home” in your body?

Do you have any concerns with respect to **alcohol** or **non-prescribed drugs**?

Please tell me if you have ever had any **emotional** or **psychological problems**.

If yes, please tell me whether you have had any **treatment** for them.

THANK YOU FOR FILLING IN THIS QUESTIONNAIRE

Appendix no 7: Setting of Interviews

Setting of Interviews	Number
At hospital	33
At home	7
Total	40

Appendix no 8: Interview Dates

	Interview Dates between April 2016 – August 2017			
Patients	First interview	Second interview	Third interview	Fourth interview
A	Apr'16	May'16	Jul'16	Sep'16
B	Apr'16	May'16	Jul'16	Sep'16
C	May'16	Jun'16	Sep'16	Nov'16
D	Jun'16	Jun'16	Sep'16	Dec'16
F	Jul'16	Aug'16	Sep'16	Nov'16
G	Sep'16	Oct'16	Dec'16	Jun'17
J	Oct'16	Nov'16	Dec'16	Mar'17
K	Nov'16	Jan'17	Mar'17	Apr'17
L	Nov'16	Dec'16	Mar'17	Jun'17
M	Feb'17	Apr'17	May'17	Aug'17
Total	10	10	10	10

Appendix no 9: Length of Interviews

Length of Interview	Number
< 30 min	2
31 - 40 min	13
41 -50 min	16
51 - 60 min	9
Total	40

Appendix no 10: DIAGNOSIS – Referral to Hospital & Psychological Reactions

	Referral to Hospital			Psychological Reactions					
Patients	After routine mammogram & letter	After finding a lump	During treatment of another illness	No symptoms & disbelief	Shock & panic	Not knowing what's going on	Fear of spread	Fear of dying	Intrusive cancer thoughts
A	X				X	X	X	X	X
B	X			X	X	X			
C	X			X	X	X	X	X	
D			X					X	
F	X			X	X				
G		X		X	X			X	X
J	X			X	X	X		X	X
K	X			X	X	X	X	X	X
L		X			X		X		
M	X			X	X	X	X	X	X
Total	7	2	1	9	9	6	5	7	5

Appendix no 11: DIAGNOSIS – Extent & Grade of Cell Pathologies

	Extent & Grade of Cell Pathologies		
Patients	Knowing type & size of cancer	Knowing spread	Not having psychologically digested what's going on
A	X	X	X
B	X	X	X
C	X	X	X
D	X		
F	X	X	X
G	X	X	X
J	X	X	X
K	X		X
L	X	X	
M	X	X	X
Total	10	8	8

Appendix no 12: TREATMENT – Surgery

	Surgery					
Patients	At least a rough idea about op	Not wanting to know about op	Own decision about op	Anxiety about op	Thoughts about operation	Thoughts about recovery
A	X		X	X	X	X
B	X		X		X	X
C	X				X	
D	X				X	X
F	X		X		X	X
G	X	X	X	X	X	
J	X				X	X
K	X		X	X	X	X
L	X		X	X	X	X
M	X	X		X	X	X
Total	10	2	6	5	10	8

Appendix no 13: TREATMENT – Chemotherapy

	Chemotherapy	
Patients	Difficult side effects	Not able to continue the treatment because of side effects
J	X	
L	X	X
M	X	X
Total	3	2

Appendix no 14: TREATMENT – Radiotherapy

	Radiotherapy		
Patients	Ideas about radiotherapy	Thoughts about travelling & positioning	Treatment itself & staff
A	X		X
C	X	X	n/a
D	X	X	X
F	X	X	X
G	X	X	X
J	X		
L	X		X
Total	7	4	5

Appendix no 15: TREATMENT - Endocrine Therapy

	Endocrine Therapy	
Patients	Worries about side effects	Experience
A	X	X
B	X	X
G	X	X
K	X	X
L	X	
Total	5	4

Appendix no 16: SUPPORT - Support from Partners

	Support from Partners		
Patients	Partner	Having no emotional support from partner	Having practical support
A	X	X	X
C	X	X	X
D	X	X	
G	X	X	X
J	X	X	X
K	X	X	
L	X		X
M	X	X	
Total	8	7	5

Appendix no 17: SUPPORT – Support from Other Family Members & Friends

	Support from Other Family Members & Friends		
Patients	Children supporting	Children not supporting	Friends supporting
A	X	X	
B	X	X	X
C	X	X	
D	X	X	X
F	X	X	X
G	X		X
J	n/a		X
K	X		X
L	X	X	X
M	X	X	X
Total	9	7	8

Appendix no 18: SUPPORT – Support from Hospital Staff & Work Colleagues

	Support from Hospital Staff & Work Colleagues		
Patients	Positive hospital experience	Negative hospital experience	Experience with work colleagues
A	X		X
B	X	X	X
C	X		X
D	X		
F	X	X	
G	X		
J	X		
K			X
L	X	X	
M	X	X	
Total	9	4	4

Appendix no 19: SUPPORT – Emotional Loneliness

	Emotional Loneliness	
Patients	Negative experience	Positive experience
A	X	
B	X	
C	X	
D	X	X
F	X	X
G	X	
J		X
K	X	X
L	X	
M	X	
Total	9	4

Appendix no 20: LOSSES – Patients’ Own Illnesses

	Patients’ Own illnesses	
Patients	Previous cancer related illnesses	Other illnesses & conditions
A	X	
B		
C	X	
D		X
F	X	
G	X	X
J	X	
K		
L		X
M		
Total	5	3

Appendix no 21: LOSSES - Other People’s Illnesses

	Other People’s Illnesses (people still alive)	
Patients	Cancer	Other illnesses, conditions
A	X (1)	
B		X
C		X
D		X
F		
G	X (3)	X
J		
K		
L		
M	X (4)	
Total	3 (8 cancers)	4

Appendix no 22: LOSSES – Previous Deaths

	Previous Deaths		
Patients	Deaths from cancer	Deaths from other illnesses, accidents	Stillborn babies
A	X (2)	X (1)	
B	X (1)		
C		X (3)	X
D	X (4)	X (1)	X
F	X (5)	X (1)	
G	X (6)	X (1)	
J	X (3)	X (3)	
K	X (2)		
L	X (2)		X
M	X (2)	X (1)	
Total	9 (27)	7 (11)	3

Appendix no 23: LOSSES – Loss of Identities & Relationships

	Loss of Identities & Relationships		
Patients	Loss of matriarchal identity	Loss of sexual identity	Loss of relationship
A			X
B			X
C	X		X
D	X		X
F			X
G			X
J			
K			X
L		X	X
M	X		
Total	3	1	8

Appendix no 24: IMPACT – Impact on Body

	Impact on Body						
Patients	Having a restricted, changed body	Having pains	Having problems with breast	Experiencing tiredness	Having sleeping problems	Having problems with over-eating	Experiencing anger towards one's body
A	X	X	X				
B	X	X					
C							
D	X	X		X			
F							X
G	X	X		X	X	X	
J							
K	X	X	X	X			X
L	X	X	X	X		X	
M	X	X		X	X	X	
Total	7	7	3	5	2	3	2

Appendix no 25: IMPACT – Impact on Mind

	Impact on Mind						
Patients	Being left to one's own devices	Fearing recurrence	Fearing future	Lucky & experiencing some positive development	Feeling empathy towards others	Thoughts about death	Mind still being occupied by cancer experience
A	X	X	X	X	X	X	X
B	X		X				X
C		X	X	X	X	X	X
D	X			X		X	X
F				X	X		X
G	X	X		X			X
J				X		X	X
K	X	X	X	X	X	X	X
L	X	X		X		X	X
M	X			X	X	X	X
Total	7	5	4	9	5	7	10

10. PSYCHOANALYTIC GLOSSARY

Acting out

Acting out is a defence mechanism where thinking and feeling difficult emotions is bypassed and replaced by an action; for example, the analysand might walk out on the analyst rather than feel and verbalise his/her dissatisfaction for further consideration.

Cathexis

Cathexis means the process by which an individual is investing (cathecting) his/her emotional energy into another individual, concrete object or idea; for example, somebody may be emotionally cathected with a sports team or with an interest in detective novels, representing /symbolising multiple issues for him/her. The main point is that psychological work has been done on the raw emotion or drive.

Containment

A term originally used by Wilfrid Bion, meaning emotional containment. The analyst /parent creates an atmosphere of safety for the analysand /child so that he/she can bring all kinds of difficult feelings to the consulting room/to the parent for attention. The regular times for the sessions and the stable physical setting in a psychoanalytic treatment are also important aspects in creating this kind of atmosphere.

Conversion hysteria

A term originally used by Charcot, Freud's teacher in l'Hopital Salpêtrière, in Paris. Conversion hysteria is a defence mechanism where unconscious psychological conflicts and/or ideas are replaced by physical symptoms, such as numbness, blindness, paralysis or various pains, for which there is no organic cause. The physical symptoms unconsciously represent/symbolise the psychological issues, for example an arm may become paralysed, unconsciously representing a defence against hitting someone.

Countertransference

This is used in different ways, but the analyst's countertransference includes his/her conscious and unconscious feelings, and attitudes evoked by the patient. The analyst needs to disentangle his/her countertransference reactions from those reactions which are his/her own personal responses to the patient. An example might be feeling anxious about a patient who is talking about an impending operation.

Defence mechanisms

The ego uses a wide variety of defence mechanisms in order to deal with different conflicts in an individual's life. These mechanisms operate at an unconscious level helping to reduce feelings, such as anxiety, sexuality, anger and guilt. Common defence mechanisms in everyday life are repression, denial and projection.

Denial

Denial is a defence mechanism where the individual unconsciously refuses to accept aspects of a given reality or aspects of himself/herself because the acceptance would create overwhelmingly

difficult feelings. Denial can be seen as just a normal reaction to a stressful situation but in its extreme it can lead to a psychotic reaction where the individual has lost touch with his/her external reality, for example believing that one can fly.

Depersonalisation

This is a state within a self where the individual's mind and body do not feel they belong to the individual anymore. He/she may experience as being a detached observer of himself/herself.

Dreams

Dreams are mental events that consist of hallucinations involving imagery and emotions. Dreams occur during the rapid-eye movement (REM) stage of sleep. Freud called dreams a 'royal road to the unconscious'. He stated that our current concerns and unconscious childhood wishes and demands, present during the day, require gratification and response. Our dreams are disguised wish fulfilments for these demands allowing us to continue sleeping. In nightmares our thoughts and feelings become too 'raw' and insufficiently disguised, breaking into our consciousness and often waking us and in this way the dreamwork fails to preserve sleep. To illustrate how the dreaming works, is a simple dream of someone fed up with winter who might be dreaming of being on the beach in a hot climate (a wish fulfilment).

Ego

Freud in his 'structural model' divided the mind into three parts: id, ego and superego. The ego tries to balance between the drives coming from the id and the moral demands of the superego. The ego is responsible for the development of various skills which the individual needs in order to function in the world; such as impulse control, digesting perceptions, evaluation and judgement, and balancing internal and external realities.

Ego ideal

The ego ideal, is a part of the superego and contains the individual's unflawed standards, values and moral ideals. His/her failure to meet these goals can cause feelings of guilt or shame, while success can boost his/her self-esteem.

Free association

When using free association thinking, we are not concentrating on anything particular but are moving from one idea to the next one in a chain of associations until one comes across something not too acceptable when the associations do not flow so freely anymore.

Holding

D.W. Winnicott's term referring to the mother's technique of responding both physically and mentally to her infant's/child's needs. This strengthens the infant's early ideas of his/her mother as a safe person to communicate with, and also the infant's ability to experience his/her own body and its demands as the place wherein he/she can securely live.

Holding environment

Winnicott's term 'holding' environment refers to that supportive and unique environment the analyst/therapist creates for his/her patient. Winnicott likened this position to a mother's nurturing and caring attitude and actions towards her child (this is explained above underneath the heading of 'Holding').

Id

The id is that part of the mind which contains the individual's most basic and instinctive drives. It is dominated by sexual and aggressive desires seeking release and the reduction of tension coming from these drives is felt pleasurable. The contents of the id are entirely unconscious, but its derivatives are expressed in many psychological and physical forms.

Infantile psychotic anxieties

Melanie Klein's term for very early paranoid-schizoid type of persecutory anxieties. These anxieties are linked with the very early developmental stages and the young baby's fears of both its annihilation and of its own destructiveness.

Libido

A term generally used to refer to the individual's positive life forces of which the sexual components are best known. In the infant these positive life forces are particularly expressed through one's own various body zones, oral, anal and genital, as well as in time more towards whole persons, self and others.

Metapsychology

General theory of psychoanalysis which includes clinical theory, concepts built on it and the generalisations derived from it. Freud first used this term in 1856 when he referred to his addition of unconscious processes to the conscious ones of traditional psychology.

Mirroring

D.W. Winnicott's term referring to the earliest phase of the infant's emotional development when he/she sees himself/herself in mother's eyes. The infant's sense of self starts to develop with the help of mother's look which reflects back her infant's growing sense of self.

Object

In psychoanalytic language the object means a person. The subject cathects his/her object with instinctual satisfaction and desire; for the child his/her mother is a highly emotionally cathected 'object'. A psyche is developing in relation to others and Freud saw that early cathexis of objects (people) with libidinal energy is a central aspect of human development. An internal(ised) object is the mental representation of an external object (another person).

Oedipus Complex

Freud used the Greek myth of Oedipus to illustrate a developmental stage between the ages of three and six years when a child desires to have the parent of the opposite sex all to himself/herself and wanting to exclude the rival parent who is of same sex with him/her.

Parapraxis (Freudian Slip)

A 'small' mistake, such as a slip of tongue or forgetting someone's name, may reveal the individual's unconscious desire or conflict.

Phantasy

A phantasy loosely refers to an imagined situation where the imagining individual's desires or aims are expressed. It also refers to images of the individual's 'objects' or an imagined relation between his/her 'self' and the other. Psychoanalytic convention uses the word 'fantasy' for ideas at the

conscious level, as a daydream for example, and 'phantasy' for those ideas that are unconscious. An example might be of a girl consciously excessively experiencing herself as a very important person following some setback which stirred up in her an unacceptable phantasy of being insignificant.

Pleasure principle

Pleasure principle is a driving force in the id. It wants to gain immediate gratification for its needs by obtaining pleasure and avoiding any tension or pain. When our basic needs are not met or fantasies/phantasies of them being met are no longer working, feelings of anxiety will develop.

Projection

Projection is a defence mechanism where in phantasy the individual gets rid of unacceptable or unwanted feelings, thoughts and traits attributing them outside of his/her 'self' and into other people or institutions. Projections are common in everyday life, for example in our prejudices. Extreme use of projections will lead to a paranoid state of mind where the outside world becomes hostile and threatening.

Projective Identification

A term developed by Melanie Klein to describe a process where the person unconsciously projects unwanted aspects of his/her 'self' into the other person to get rid of them (projective phantasy) or alternatively enters into the mind of another person to acquire desired aspects of the other's 'self' (introjective phantasy). This process usually happens in a close relationship, for example between mother and child, between analyst/therapist and patient or between parts of a couple.

Psychoanalysis

Psychoanalysis is an intensive form of treatment lasting typically for several years. The sessions take place 4-5 times weekly, each session lasting 50 minutes, the analysand lying on the couch and the analyst sitting behind him/her. The analysand's free associations, phantasies and dreams are ways into exploring his/her unconscious conflicts and making them conscious with the aid of the analyst's understanding (interpretations). The analysand's resistance to this process is also essential to explore. This intensive treatment has the possibility of analysing extensive aspects of the person, his/her character and history.

Psychodynamic & psychoanalytic psychotherapy

Psychodynamic or psychoanalytic psychotherapy is a form of treatment which is derived from psychoanalytic theories and based on a psychoanalytic model of mental functioning. It is primarily for individuals who will benefit from a more focused /limited method of treatment that is actively concentrating on the problematic realities of one's daily life.

Regression

A defence mechanism where the individual regresses to earlier developmental stages. It is used in order to avoid difficult emotions when faced with a stressful situation. In regression the ego will withdraw itself in a way that has similarities to earlier stages of development.

Repression

A defensive process whereby unacceptable ideas or memories and drives are unconsciously censored and appear in a substituted or sublimated form.

Resistance

In resistance, the analysand unconsciously opposes the analytic work and the uncovering of painful memories and ideas during psychoanalysis. While resistance initially occurs unconsciously, it may persist long after the analysand is made consciously aware of this.

Self

Self is the individual's conscious and unconscious subjective feeling about who he/she is and how he/she sees himself/herself. Winnicott's statement that 'the self is one's body' reflects the idea that in normal circumstances the self-feeling is closely linked with the individual's physical body.

Separation-individuation phase

A term originally used by Margaret Mahler referring to a young child's developmental stage after the symbiotic phase. In the latter half of the first year a young infant starts increasingly to feel separate from his/her mother. Related to this separation, there is also an individuation process where the child will gradually develop his/her sense of self, his/her ego, separate identity and his/her own cognitive abilities. The separation-individuation process will normally be relatively complete by the end of the third year.

Superego

Superego is the part of the mind that acts as the individual's conscience. Its function is to inhibit or punish behaviour which is unacceptable for the individual's ego ideal. It plays an important role in social functioning.

Symbiotic phase

A term originally used by Margaret Mahler when referring to the earliest developmental phase during the first six months of the young infant's life when he/she experiences himself/herself and his/her mother as an undifferentiated single unit.

Transference

In the transference the analysand projects into and onto his/her analyst feelings, thoughts and experiences which belong to his/her relationships with other important people in his/her life, usually the childhood figures. Transference is an important concept in psychoanalysis because it demonstrates that past experiences impact the present. Interpreting transference in the psychoanalytic setting can help to clarify the analysand's unresolved conflicts in other relations. An example would be some analysands who keep saying 'sorry' as if in their minds they are endlessly doing something that upsets the parental figure, now in the person of the analyst.

Unconscious

In his 'topographical model' Freud introduced three parts (levels) of the mind; the conscious, preconscious and unconscious. The preconscious is at that particular moment unconscious but available to consciousness whereas the dynamic unconscious part of the mind stores those feelings, thoughts and urges which the individual is not to be aware of. These unconscious mental contents and processes influence our conscious experiences through transformations and distortions in the higher layers of the mind. The unconscious can express itself more obviously in the process of free association, but also in distorted forms in our anxieties, physical symptoms, dreams, slips of tongue and in the analysand's transference relationship to his/her analyst.